

## MASTER OF SCIENCE BY RESEARCH

### Perceptions of the role of the breast care nurse in the breast screening assessment unit

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**PERCEPTIONS OF THE ROLE OF THE BREAST CARE NURSE  
IN THE BREAST SCREENING ASSESSMENT UNIT**

**By**

**J. M. CLARKE**

**A thesis submitted in  
partial fulfilment of the University's  
requirements for the degree of  
MASTERS BY RESEARCH**

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## **ABSTRACT**

### **AIM**

This study aimed to explore the role of the breast care nurse (BCN), gain greater understanding of their function and inform future practice within the Breast Screening Assessment clinic (BSAC).

### **Methodology**

The research was based on qualitative research and utilised an interpretive qualitative approach within a phenomenological framework. Data was collected through 12 semi-structured interviews with clients, BCNs and radiology staff working in a BSAC. Analysis of the interview data utilised a method of Inductive Thematic Analysis.

### **Findings and discussion**

Five categories were generated from the data, 'Person Centred Care', 'Interactional Support', 'Defining the Role', 'Organisational Issues' and 'Clinical Practice/New Opportunities'. Views and experiences from each participant were considered within the context of these themes.

The findings of this study recognised the proficiency of the BCN in their communication skills and provision of psychological support. However, role ambiguity and organisational issues appear to impact on BCN performance within this setting. There are various reasons for this, including lack of role definition, service limitations, team dynamics and effective team working. Role development is seemingly influenced by individual BCN perception of the scope of the role, level of experience and educational requirements.

A table of recommendations is given to inform enhanced effectiveness of the BCN role in BSAC and optimal client care. Further research is recommended to evaluate the effectiveness of the BCN in terms of breast awareness within this setting.

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# **CHAPTER 1**

## **INTRODUCTION AND LITERATURE REVIEW**

### **1.1 Introduction**

Guidelines for nurses working within the National Health Breast Screening Programme (NHSBSP) were initially published in 2002 and revised 2008. These guidelines suggest that the provision of appropriate nursing care and support is dependent on the presence of a clinical nurse specialist, also known as a breast care nurse (BCN), within the Breast Screening Assessment clinic (BSAC). Knowledge and skills of these BCNs have to be continually updated, evidence based and open to regular review, to ensure high standards of practice are achieved and maintained (NHSBSP 2008).

This dissertation reports a qualitative study designed to explore the role of the BCN in BSAC. The study aimed to capture key stakeholders' perspectives and gain greater understanding and appreciation of the role within the assessment setting through in depth semi-structured interviews. This chapter begins by describing the justification for the research and a review of the literature.

### **1.2 Background**

#### **Justification for undertaking the study**

There has been considerable progress in the management of breast cancer over the last twenty years. The implementation of the National Health Service Breast Screening Programme (NHSBSP) (Forrest 1987), innovation in surgical techniques, increase in additional therapies and discoveries in genetic science, have had a major impact in reducing breast cancer related deaths. In the current climate of consumerism and emotive association, breast cancer continues to find itself on the political agenda. As a consequence of ongoing national strategic progress (DH 2007), a comprehensive high quality service has evolved, with the development of a specialist core breast care team. Symptomatic and screening teams co-exist to assess patients/clients attending either from GP referral to symptomatic outpatient clinics, or as a consequence of invitation through the NHSBSP to BSAC. Integral to both teams is the BCN. However, for the

purpose of this study, the aim is to specifically explore the role of the BCN within the BSAC.

The BCN role emerged as early as the mid eighties and became integrated into the NHSBSP, adopting an active multi-tasking clinical role in BSAC. Forrest (1987) recommended that the specialist team should include an appropriately trained BCN to support those women attending the screening assessment process. The BCN's role provides a unique opportunity for the "advanced expert" practitioner to maintain the focus of patient care. One of the major expectations of the role is to provide information and psychological support for all women who have been recalled to the BSAC and perceive themselves to be at risk of a breast cancer diagnosis (NHSBSP 2008).

An invitation to second stage assessment is generally recognised as leading to much higher levels of anxiety and distress for the 7% of recalled women (NHSBSP 2008). This was a finding validated by (Wilson et al 2001), who recommended that;

"The service should ensure that all women recalled for assessment receive information, advice and support appropriate to their needs from the CNS in breast care".

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Ong & Austoker (1997) provided evidence supporting the role that the BCN plays in identifying and reducing psychological morbidity associated with attendance at a BSAC. The main findings from this study identified the importance of the nurse in communication and information giving, prior to further investigation within this setting. The idea for this study arose following recognition of inconsistencies in practice, creating confusion and ambiguity for BCNs in the BSAC across the West Midlands region. These became apparent as a consequence of the researcher's professional responsibility for undertaking compulsory peer assessment reviews. In the light of this knowledge, it was perceived that this discrepancy could exist in other parts of the United Kingdom and thus provided an opportunity for research.

There is anecdotal evidence relating to the BCN role and differences in role expectations, perhaps arising from individual interpretation, practice variation and thus



uncertainty. This has been further compounded by the paucity of research, the lack of clarity, vague role obligations, confusion surrounding the definition and functions of the BCN and, most importantly, the lack of evidence to support the effectiveness of the BCN in BSAC. I would suggest this has led to de-motivation and inhibition of role development. I would suggest that until the role has been critically examined, the contribution of the BCN cannot be assessed, either in terms of patient satisfaction, quality of life outcomes and job satisfaction or, as is increasingly necessary in today's economic climate, cost effectiveness.

There might be further implications for the BCN role in BSAC as a result of the new collaborative working initiative, introduced into many of the units within the NHSBSP throughout the UK. This has led to a change in skill mix, with the initiation of a four tier staffing development to address staff shortages. In place of radiographers, non-professional staff are being trained to perform mammograms, allowing radiographers to extend their roles to incorporate tasks previously undertaken by radiologists. This change in roles and acquisition of new skills and competencies for the radiology team, might have repercussions for the BCN role. Consequently, the BCN may no longer be perceived as an integral core and valued member of the NHSBSP. Working within the BSAC has been a core component of the BCN's role since the introduction of the NHSBSP. This study is intended to provide greater clarity of the role and identify possible opportunities to develop practice and scope for the BCN. This is not only in the traditional arena of psychological support but also, potentially, in health education and health promotion (Poole 1996). This is an important aspect, where the researcher believes BCNs have not been truly developed and are an under utilised resource, despite being in a prime position of influence.

Finally, this present study aims to achieve greater insight of the role and promote evidence-based findings for both the BCNs and stakeholders within the BSAC. Disseminating the findings of this study has the potential to inform future practice and, as a result, impact on the performance of this particular substantial body of nurses.

### **1.3 Literature review**

The purpose of this literature review is to identify and critically appraise the relevant literature pertaining to the BCN role in the BSAC, with particular reference to their practice within this setting. This review focuses on clinical nurse specialists (CNSs) and nurse practitioners (NPs), both roles are considered to be advanced specialist roles.

Over the last two decades, there has been a substantial increase in the number of CNS posts in the UK and, with it, enormous diversity in specialist practice. Much has been written about the theory and practice of the CNS role by theorists and researchers who have attempted to explore the complexity of the advanced practice role. This has stimulated much debate and created a need to identify the various components and defining characteristics of the individual CNS. Many authors describe the multi-faceted role of the CNS and the fact that the role is continually evolving. The process of evaluating the role is linked to skills, competence and performance, and has become a somewhat complex task (Wilson-Barnett & Beech 1994).

#### **1.3.1 Inclusion criteria**

Criteria for considering studies for this review

Inclusion criteria

- Studies conducted in relation to the BCN role within the Breast Screening Assessment Clinic, or studies attempting to explore the Clinical Nurse Specialist (CNS) and Nurse Practitioner (NP) roles
- Primary research inclusive of all methodologies and methods
- Written in English
- Published and unpublished literature

#### **1.3.2 Search strategy**

The initial review focused on research articles that discuss nursing roles in relation to breast screening. However, this was somewhat limiting due to the paucity of research has been conducted in that setting. The review was extended to include broader issues relating to the CNS, a generic title for nurses with specialist skills, in terms of role development and effective practice. All studies that met the specified inclusion criteria

were deemed as useful to the project; exploring the BCN role in the BSAC.

The search terms used to retrieve information pertinent to the area of research are detailed in Appendix 1 and are designed to maximise sensitivity for relevant literature written in English.

The following electronic databases were searched

- CINAHL 1982 to February 2005
- MEDLINE 1996 to December 2005
- EMBASE 1996 to December 2005
- The COCHRANE Library database 1996 to December 2005

An initial search was conducted in 2005 prior to commencing the study using CINAHL database; CINAHL is the largest database for nursing and allied health literature and gives the broadest coverage of nursing topics. The search from 1982 - 2005 provided a comprehensive overview and reflected any change in specialist nursing practice over the twenty three-year period since the inception of the CNS and specifically the BCN. The search was further supplemented by studies identified in articles retrieved. Papers identified as a result of the searches were then subjected to the inclusion criteria and either included or rejected. A further search was conducted March 2008 and further repeated May 2009 utilising the same search strategy as previously identified in Appendix 1. This captured only one further article.

As this dissertation was being completed, 3 further papers were identified (Beaver et al 2006, Halkett et al 2006 & Cruickshank et al 2009) which appeared to have relevance. Records from each of the databases were collated; titles, keywords and abstracts were then appraised for relevance. If this was not achievable, the full text was obtained for further evaluation prior to acceptance or rejection. The criterion for assessing the quality of research studies utilised a process of critical analysis and evaluation (Burns & Grove 2001). Appraisal was intent on achieving an understanding of each of the studies, the methodology and its influence and understanding of the subject matter.

### **1.3.3 Review**

A total of fourteen relevant studies were identified and were mostly from the UK. They used a range of qualitative approaches including focus groups; individual interviews and one systematic review (Lloyd Jones 2005). The studies reviewed, looked at the generic role of CNS; others explored the BCN role specifically and two studies considered the BCN within the BSAC.

Studies were therefore, categorised into three groups:

- The CNS role
- The BCN role
- The role of the BCN in BSAC

**Table 1 Literature overview**

STUDY	COUNTRY OF ORIGIN	STUDY DESIGN	SAMPLING	METHOD OF DATA COLLECTION	METHOD OF DATA ANALYSIS	ROLE	LIMITATIONS
<b>The CNS role</b>							
Bousefield (1997) A phenomenological investigation into the role of clinical nurse specialist	UK	Phenomenology	7 CNSs	Interviews	Giorgi's (1975) method	CNS role	Lacked detail of interview schedule and type of questions
Bamford & Gibson (2000) The Clinical Nurse Specialist: perceptions of practising CNSs of their role and development needs	UK	Exploratory	39 hospital based CNSs	Focus groups	Grounded Theory	CNS role and development needs	Views of CNSs only
Cox & Ahluwalia (2000) Enhancing clinical effectiveness among clinical nurse specialists	UK	Exploratory	20 CNSs/NPs	Observation & focus groups	Thematic Analysis	Clinical effectiveness of CNSs/NPs	Recruitment process not clear Low attendance of CNSs at focus groups
McCreddie (2001) The role of the clinical nurse specialist	UK	Grounded Theory	20 CNSs	Semi structured interviews	Constant comparison (Struass & Corbin (1990))	CNS role	Lacked detail of interview schedule and type of questions
Lloyd Jones (2004) Role development and effective practice in specialist and advanced practice roles in acute hospital settings	UK	Systematic review	N/A	Qualitative studies	Ritchie & Spencer (1994)	CNS role development and effective practice	Qualitative articles only. Conclusions limited as focus on facilitators and barriers to practice apparent on only few studies

Dunn et al (2006) A framework for description and evaluation of the nurse specialist role in south Australia	Australia	Illuminative Evaluation	30 hospital based CNSs	Focus groups	Data collection and analysis inter-related for flexibility & reflexivity	CNS role	Sampling & recruitment not described. Data collection not clear
<b>The BCN role</b>							
NBCCS (2003) An evidence-based specialist breast nurse role in practice	Australia	Quantitative	Newly diagnosed breast cancer patients >18 years of age	Patient logs & patient assessment records	Statistical analysis using SAS software	BCN role on practice	Study design not clear
Amir et al (2004) The professional role of breast cancer nurses in multi-disciplinary breast care teams	UK	Qualitative	BCNs Surgeons Oncologists Radiologists Pathologists Nurses Doctors Clerical staff	Interviews & observation	Grounded Theory	BCN role	Study did not address BCN role from patient perspective
Liebert & Furber (2004) Australian women's perceptions of a specialist breast nurse model	Australia	Survey	Newly diagnosed breast cancer patients >18 years of age	Questionnaires	Not identified	Women's perception & BCN model	Sampling strategy not identified. Specialist BCN model not described. Predetermined interventions not identified. Data analysis not discussed
Beaver et al (2006) Meeting the information needs of women with breast cancer: Piloting a nurse-led intervention	UK	Non randomised control trial	Women having completed primary breast cancer surgery	Interviews	SPSS-v11.5.	Information needs of women: BCN led intervention	Lack of consistency & stability in data collection due to change of BCN team

Halkett et al (2006) The role of the breast care nurse during treatment for early breast cancer: The patient's perspective	Australia	Hermeneutic Phenomenology	Women diagnosed with breast cancer & completed treatment within 1 year	Interviews	Wholistic/ Sententious approach van Manen (1990)	BCN role : the patient perspective	Detail on the interview schedule and the type of questions were not apparent
Cruickshank et al (2009) Specialist breast care nurses for supportive care of women with breast cancer	UK	Systematic review	N/A	RCTs studies	Systematic	BCN supportive care of women with breast cancer	Review limited to quantitative studies limiting comprehensive representation
<b>The BCN in BSAC</b>							
Ong & Austoker (1997) Recalling women for further investigation of breast screening: women experiences at the clinic and afterwards	UK	Survey	8 Breast Screening Units	Postal questionnaires to clients & semi structured interviews with staff	Not described, referenced to further article	Women's experience at BSAC	Overall response rate from client group 70%
Scott (2005) Women's perceptions of their breast screening 'Assessment' appointment and the role of the clinical nurse specialist	UK	survey	3 BSAC & 90 CNS teams in UK	Postal questionnaires to clients and CNS teams	Descriptive statistics	Women's perception of BSAC	Overall response rate from client group 50%

## **The CNS role**

Of the 14 studies retrieved, only 6 ( Bousefield 1997, Bamford & Gibson 2000, Cox & Ahluwalia 2000, McCreddie 2001, Lloyd Jones 2004, Dunn et al 2006) attempted to identify the generic role of the CNS. Three articles, (Bamford & Gibson 2000, Lloyd Jones 2004, Dunn et al 2006) detailed the key components of the role, namely: clinical, educational, management, research and professional development. The other 3 studies focused on the broader aspects, describing factors that might impact on CNS practice: personal characteristics, role ambiguity, lack of a role development framework, and organisational support.

Lloyd Jones' systematic review (2004) demonstrated difficulties encountered by CNSs impeding effective practice. This systematic review attempted to define the scope of the CNS role and identify facilitators and barriers to role performance and development. Other elements to emerge highlighted the various constraints CNS's face, for example: isolation; lack of support; role ambiguity; role conflict; time management; increasing workload and burnout. Combinations of personal qualities, professional development and collaborative relationships with key personnel were also recognised as pivotal to the success of the CNS role. These findings underline the need for greater understanding and clarity to minimise role ambiguity, substantiate clearer role definition and gain co-operation of key stakeholders to maximise support, development and effective practice. The findings are also consistent with research by Bamford & Gibson (2000) and Dunn et al (2006) which in turn built on Bousfield's (1997) earlier work. Bamford & Gibson (2000) further extended the research by identifying a constructive professional development framework for CNSs. The aim of the framework is to assist professional development by providing a competency focused individual development plan, supporting improved specialist practice and thereby establishing a structured clinical career pathway for both novice and expert CNS's. Closely linked with this are findings from Cox & Ahluwalia (2000) and Lloyd Jones (2004) that identify mentorship as an important factor supporting the newly appointed CNS during role transition.

Two of the most important factors identified as barriers by Lloyd Jones (2004), and seemingly interconnected, were role ambiguity and unsupportive attitudes from other



health professionals. Role ambiguity arose from differing expectations of individuals, precipitated by lack of clarity and an inability to communicate understanding of role objectives and boundaries to key stakeholders. This correlates with Cox & Ahluwalia's (2000) findings that suggest role ambiguity was noticeably apparent in the novice CNS who also struggled to clarify responsibilities and expectations of the role.

McCreddie (2001) recognised overwhelmingly that the key role of the CNS is based around clinical practice and the provision of supportive care, facilitating and negotiating the patient through the treatment pathway. The main findings from this study focused on the need for role definition and supportive strategies to promote effective role performance. Clinical workload was seen as the core element of the CNS role and deemed to take priority over other aspects of responsibility, specifically that of research, which emerged as an important but neglected aspect of the CNS role. However, earlier work by Bousefield (1997) suggested that the role components of education, research and consultancy should be developed and successfully incorporated to validate the true potential of the CNS role. Dunn et al (2006) took this work further and explored a theoretical framework for the description and evaluation of the CNS. The premise of this study centred on role clarification and the impact of the specialist nurse in health care. Five guiding principles emerged from the data to provide strategic evaluation of the CNS role. These were identified to reflect: components of the role, benefits to patients and the health care system, flexibility, approach to service demands and political awareness responding to changing health care practice.

It is concluded from the studies to date, that further research is required to assess CNS performance specific to clinical and educational interventions associated with measurable patient outcomes and cost benefit analysis of their practice. The apparent lack of emphasis on the nurse specialist as an applied researcher also warrants further investigation.

## **The BCN role**

Six studies were identified, (The National Breast Cancer Centre (NBCC 2003), Liebert & Furber 2004, Amir et al 2004, Beaver et al 2006, Halkett et al 2006, Cruickshank et al (2009); five evaluated patient perception of care delivery from the BCN following early breast cancer diagnosis and incorporated components associated with communication, information, access and support. Amir et al (2004) considered the professional role and outcomes linked to management and leadership performance.

The systematic review undertaken by Cruickshank et al (2009) concluded that there is limited evidence at this time to support some of the BCN's interventions. However, it may be reasoned that the original body of research was somewhat limited, coupled with the fact that the review was restricted to randomised control trials (RCTs), limiting the evidence and potential applicability of the results. This is because most of the research around the role of the BCN has been qualitative, the aim of which to capture the intricacies of their activity. The review also found evidence to suggest that BCNs' interventions provided short term, rather than long term, benefits for patients. Consequently, the recommendations highlighted the need to promote a more focussed and sustainable approach through the treatment trajectory to maximise patient support. Further to this, there was acknowledgement that supportive patient care was not the exclusive remit of the BCN but was multi-disciplinary. However, the term 'supportive care' was not defined within the context of the BCN and associated individuals within the multi-disciplinary team. The study by Halkett et al (2006) suggested that care from all health professionals needs to be designed to compliment that of care delivered by the BCN and, in turn, is reciprocated by the BCN. This research substantiated work by Liebert & Furber (2004) that demonstrated the range of judicious BCN support providing many role facets intuitively driven by women's individual situations.

The NBCC (2003) conducted a multi-centre implementation study with four collaborating cancer centres, in both urban and remote areas of Australia, with the objective of examining the benefit of the BCN in the Australian breast cancer treatment context. Although a randomised trial methodology was not used, the findings suggested were consistent with those from earlier studies looking at the role of BCN's

with women post mastectomy, but there was no evidence relating to the role of BCNs in BSACs. However, Liebert & Furber (2004) used the model developed by the NBCC to explore women diagnosed with breast cancer perceptions of the BCN. The study found experiences of BCNs to be extremely positive and highlighted continuity of care as being of paramount importance. The majority of women recognised the BCN as being a good communicator and identified advocacy as an important skill conveying women's needs to doctors in the treatment team, a finding substantiated in previous studies (NBCC 2003, Amir et al 2004). A smaller study by Halkett et al in 2006 also reported that BCNs were highly valued.

The actual role of the BCN was investigated by Amir et al (2004) using a grounded theory approach. This study provided an insight from the perspective of 16 multi-disciplinary breast teams in England but, unfortunately, the perspectives of patients or hospital senior management teams were not included. Hence, it can be argued that a less than comprehensive representation of effectiveness to further supported performance and development, both clinically and managerially, was presented. However, the findings did indicate that BCN's practice at an advanced level. Another approach to the role of the BCN was studied by Beaver et al (2006) who investigated the feasibility and acceptability of BCN telephone intervention. The article provided a clear description of the study design and methodology and the researchers incorporated their own evaluation and limitations of the study. Despite a lack of consistency and stability during data collection (due to staff shortages and sickness) the findings from this study indicate that BCN led telephone interventions were a feasible and an acceptable approach to meeting information needs of women with breast cancer, with additional time saving and financial rewards to the patient.

Consumer perception has become an increasingly important aspect in service provision and shaping delivery of care. To date, attempts to measure patient perception have tended to rely on patient satisfaction scales. A disadvantage of these is the potential to extort only superficial information. In most of the studies reporting the experiences of women with breast cancer, there was evidence to suggest that the BCN played a pivotal role in providing comprehensive information allied to treatments and procedures.

Patients felt adequately prepared and well informed and this contributed to a positive patient experience.

### **The role of the BCN in BSAC**

The literature search indicated that there has been very little research undertaken on the role of the BCN in BSACs. Two studies were identified that explored women's perceptions and experiences attending BSAC. Most notably a study by Ong & Austoker (1997) has influenced the BCN role in BSAC and provided a bench mark to evidence-base clinical practice delivered by this group of nurse specialists. The inclusion of eight centres in the study promoted generalisability and, therefore, applicability to other centres in the UK. However, use of survey design to capture clients' experiences is an approach that has the tendency to provide an extensive, rather than an intensive analysis and gives rise to the possibility of a lack of capture of the complexities of human behaviour and feelings (Polit & Beck 2004). Similarly, in the study by Scott (2005) questionnaires were employed to explore the methods which best supported clients during the investigative phase of the BSAC. The overall low response rate of 50%, resulted in a loss of potentially valuable data and was exacerbated by a high percentage of missed and misunderstood questions. However, both Ong & Austoker (1997) and Scott (2005) suggest that the BCN is the key individual for providing supportive interventions. Satisfaction with the information communicated to clients was significantly higher for centres where a BCN provided women with the opportunity to talk in private, prior to the assessment process, (Ong & Austoker 1997). Conversely, Scott (2005) suggested that clients preferred and benefited from a collaborative approach from health care professionals (HCPs) in the provision of information and communication with the client within the BSAC. The Ong & Austoker study findings additionally supported actions to improve communication of assessment results and recommended that, as part of the exit consultation with the radiology team, women could benefit from BCN intervention to assist in assessment of understanding and, thereby, increase client satisfaction.

Scott's study (2005) also raised questions about the concepts of inter-professional working and task driven duties, undertaken by the BCN in BSAC. Multi-tasking was recommended as a possible alternative to collaborative working, an arrangement which

combines health care across disciplines, promoting more flexibility and, thereby, reducing protectionism and rigid demarcations, factors which adversely affect service delivery. The aim of multi-tasking was to expand individual's skills and knowledge and define work tasks common to all, together with recognition for practices that remain definitive and exclusive to each discipline (Rushmer 2005).

Further, and in parallel with Ong & Austoker (1997), Scott (2005) identified women's needs in terms of wanting information regarding harmless breast conditions. This would appear to support the notion of BCNs playing, or taking on, a more a significant role in breast awareness. An overview of literature linked to the BCN role (Poole, 1996) supports this concept with a suggestion that the BCN is in a prime position to contribute to health promotion activities. However, to date there has been very little research to demonstrate the effectiveness of such activities in terms of women's health. Poole (1996) also suggested the BCN has an important role in advocating breast awareness following the Forrest Report (1986), but cautions that further research is needed to determine the effectiveness of health promotion by the BCN, before advocating this practice.

#### **1.3.4 Summary**

The first generation of CNS's had no previous role models or job descriptors to guide them in the development of the role. Individual interpretation and motivation shaped the role with little direction and evaluation. As demonstrated by the literature, there has been some research directed at clarifying the role, implementing competencies and frameworks and developing evidenced-based research to support efficacy of the role. However, despite the proliferation of BCNs in many National Health Service (NHS) Trusts there has been little discussion or research to evaluate the BCN role in the BSAC. Although there are various conceptualisations of BCN activity within this setting, these have been attributed to theorists and a small number of studies. It is crucial to focus on nursing practice that is patient centred, interdisciplinary and evidence- based. However, this needs to be consistent with the need to demonstrate good clinical outcomes and cost effectiveness, a requirement and expectation of modern NHS service delivery. The aim therefore of this current research was to gain greater understanding, which could then be used to provide guidance and direction for BCN role development in the BSAC.

## **CHAPTER 2**

### **METHODOLOGY**

#### **2.1 Introduction**

As identified in Chapter 1 and in response to the existing gaps in the research, this study aimed to explore the role of the BCN, gain greater understanding of their function and inform future practice within the BSAC. This chapter will describe the methodological justification and design of the study.

The UK government's modernisation agenda for the National Health Service promotes the use of evidence-based practice (DoH 1997). In addition, both clinical governance and the strategy for nurses (DoH 1999) endorse the importance of ensuring that practice is evidence-based and that nurses are supported and skilled to translate research findings into practice. Sackett (2000) defines evidence based practice as:

“The integration of best research evidence with clinical expertise and patient preference optimising clinical outcomes and quality of life.”

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This approach supports the enlightenment model (Bulmer 1982) which, from the social perspective, focuses on the parts played by the various individuals. In the context of this study, the focus is on the nurses, clients, radiographers and radiologists. This model seeks to understand the social world from the perspectives of those who are a part of it. However, Bulmer (1982) further suggests that personal agendas, social relationships and the physical environment are some of the variables that merit consideration. The aim is to combine the various types of knowledge to gain understanding of how individuals think and perform, so that findings enhance understanding and contribute to development. There is a perception in nursing and medicine that quantitative research (especially randomised controlled trials) is the gold standard. Yet the fundamental principles of nursing are focused on individual patient care and therefore evidence based practice should not solely be driven from quantitative research, but should embrace the qualitative paradigm, including the enlightenment model.

Liaschenko & Fisher (1999) describe three types of knowledge that are important to nurses, i.e. case knowledge, patient knowledge and person knowledge, to justify changes in approach to practice and defend such actions to improve patient care:

- Case knowledge is primarily concerned with the nurse's knowledge of disease processes and treatment regimes
- Patient knowledge focuses on how the individual responds to treatment, how to get things done for the patient and who else might be involved in providing services for the individual
- Person knowledge is concerned with the individual and their experience of a particular disease or disability and broadens the perspective

“Seeing that individual as something more than an object of biomedical science or as someone more than a patient in a healthcare system”. Liaschenko & Fisher (1999) p38

Gerrish (2003) argues that, based on the premise that patients are experts in areas that affect them; nurses need to involve patients in decision making to provide nursing care that is responsive to the individual. Providing constructive comments for the improvement of healthcare delivery underpins the methodology for this study.

## **2.2 Choice of methodology**

Qualitative research is particularly useful for new or relatively unexplored areas, or where complexities are apparent and the need for clarity is paramount (Sim & Wright 2000). Quantitative research represents a different paradigm, emphasising measurement and analysis of causal relationships between variables not processes. Quantitative research adopts a hypothetico-deductive approach (Sim & Wright 2000), moving from the general to the specific with its main aim being to test theory. Such an approach, potentially has limited capacity to illuminate information significant for examining dimensions of human consciousness. In qualitative research it is possible to explore the intricacies of human behaviour (Moule & Goodman 2009). The focus on exploration and understanding, incorporating people's perceptions and interpretations allows

qualitative research to examine the micro, rather than the macro characteristics of the individual's world. Previous studies relating to BSAC and the BCN have been undertaken (Ong & Austoker 1997, Scott 2005). However, further work relating specifically to the BCN role in BSAC is warranted due to lack of evidence-based research. Consequently, the inductive approach is appropriate for this study, a method that proceeds from the collection of theoretical ideas to the framing of general propositions (Sim & Wright 2000). The interview schedule that guided the current study (Appendix 2) is consistent with an epistemological framework (Sim & Wright 2000). This facilitated the exploration of an individual's personal perception of an account or event and was centred on developing greater insight and understanding of the BCN role in the BSAC. Thus this research adopted an inductive approach in developing theory, a process in which the researcher proceeded from specific observations to general and abstract principles.

### **2.3 Study methodology**

This research utilised an interpretive qualitative approach within a phenomenological framework and used Inductive Thematic Analysis. Interpretive qualitative research recognises the self reflective nature of qualitative research emphasising the role of the researcher as an interpreter of the data and an individual who represents the information (Creswell 2007).

Phenomenology is rooted in philosophy and is concerned with individuals' experiences, the main aim being to examine and describe phenomena as they are experienced. The basic philosophical assumptions of phenomenology are that one can know what one experiences only by attending to perceptions and meanings that awaken the conscious awareness (Husserl 1962). This form of research is suited to exploring several individuals' common or shared experiences to gain deeper understanding, develop practice or policies to support evidenced-based care (Creswell 2007).

Within an interpretive qualitative research approach, the researcher recognises that their own background shapes interpretation of findings, acknowledging personal, cultural and historical experiences that may influence their interpretation. Thus, the researcher attempts to interpret the data framed by his/her own experiences and background (Creswell 2007).



## **2.4 Research setting**

This study was carried out in the Warwickshire Solihull and Coventry Breast Screening unit, the fourth largest screening unit in the UK. The unit provides breast screening 3 yearly for approximately 140,000 women aged 50–70. Approximately 7% of women screened are recalled to the BSAC for further diagnostic assessment. The Breast Screening unit employs a four tier working structure consisting of consultant radiologists, a consultant radiographer, advanced radiographer practitioners and radiographers. Supplementary to the radiology team is the breast care nurse who is employed to support women attending the BSAC. This structure is adopted in many of the NHSBSP units in the UK.

## **2.5 Data collection**

An interview schedule was developed to cover topics identified by the literature and the researcher's own experience, beliefs and opinions. Consequently the topics formed the basis of the researcher's experience and present practice that questioned the role of the BCN in BSAC. Questions were posed to assist exploration of the perceptions of staff and clients about the role of the BCN in the BSAC.

These related to:

- Reason for BCNs working in BSAC
- Perception of the role
- Negativity and the BCN
- Factors that contribute to the quality of care delivered and BCN contribution
- Potential BCN service developments

The aim of the interview schedule (see Appendix 5A) was to standardise data collection, minimise error and capture comparable data from all the participants (Polit & Beck 2004). It also acted as an aid memoir to focus on certain aspects and allow participants opportunity to respond freely on the subject area. To aid reliability and validity, pilot interviews were undertaken with one participant from each of the identified groups and to appraise the questions' practical application (Holloway & Wheeler 2002). Analysis identified a poor response to questions four and five. Discussions with the researcher's supervisor resulted in amendments (see Appendix

5B) and more detailed responses were gained within the same frame of reference. These pilot interviews are included in the analysis.

The intention was to conduct 18 interviews (six from each participant group). The sample size was determined on the basis of acquiring sufficient information to explore the phenomena comprehensively. However, data saturation was achieved following 12 interviews comprising four interviews from each of the participant groups. Consequently no further data was collected (Polit & Beck 2004).

Audio taped semi-structured interviews were conducted by the researcher with each participant. The interviews were audio taped to minimise misinterpretation of the responses to avoid disruption of the interview process associated with note taking, and to aid comprehensive data collection and analysis (Byrne 2001).

## **2.6 Sampling and recruitment**

### **2.6.1 Sampling**

A purposive sampling method was employed to select those participants who had knowledge and experience of working in the BSAC (Polit & Beck 2004). Participants were chosen from two groups, the breast screening radiology team, and breast care nurses working within the breast screening unit. Clients were selected using a retrospective convenience sampling method, having recently attended the BSAC with a normal or benign result. A positive response to participate in the study was received; no participants selected declined involvement.

### **2.6.2 Recruitment procedure**

#### **Staff group**

Participants were sent an invitation letter and participant information sheet prior to the study (see Appendix 3). These explained the research with an invitation to participate in one interview, conducted by the researcher. Instructions and an agreement slip were included in the introductory letter for potential participants to contact the researcher directly if they wanted to take part. On receipt of the agreement slip, prospective participants were contacted and arrangements for the interview confirmed. Prior to each

interview informed consent was obtained from every participant, and a consent form (see Appendix 4), signed by both the researcher and participant.

### **Client group**

Four weeks before the start of the study all clients who attended the BSAC with a normal/benign result were sent an invitation to participate together with an information sheet (see Appendix 3). However, this approach resulted in a poor uptake, with no reasons identified; therefore, with appropriate ethical agreement, the recruitment strategy was amended. It might be suggested that lack of researcher face to face contact at the introductory stage may have contributed to the lack of involvement. Consequently clients were approached by the researcher following initial discussions by the BSAC team. Those clients who showed an interest were given an introductory letter and participant information sheet by the researcher. Contact was made one week later to clients who expressed an interest in participation. Only one client declined to participate in this study because of holiday commitments. For those clients agreeing to participate, time and venue to conduct the interview were agreed. Those clients not participating in the research were made aware that their decision would not affect current or future treatment. As in the Staff group above, informed consent was obtained from every client (see Appendix 4), prior to the interview.

The interviews were conducted over a period of five months. Staff group interviews were conducted at the BSAC. Client interviews were conducted in their own homes to minimise travel difficulties due to long distance. All participants were asked to participate in one interview only. All the interviews were carried out on a one to one basis taking approximately 45-60 minutes. All participants were identified by pseudonyms only to maintain anonymity.

## **2.7 Data analysis**

Analysis of the interview data utilised a method of 'Inductive Thematic Analysis' (Creswell 2007). It is a process for encoding qualitative research, developing themes generated from raw data in a systematic way that increases accuracy and sensitivity in understanding and interpreting individuals, events and meaning (Boyatzis 1998). Data analysis concentrated on exploring the different perspectives of the groups with the aim of gaining a clearer understanding of the role.

The start of analysis comprised repeated readings of transcripts to determine key categories or commonalities among respondents' comments. Utilising a systematic and transparent process, the researcher allowed themes to emerge from the data. This approach was chosen due to the lack of existing research and theory exploring the experience. Once a transcript was coded, themes were generated to capture the essence of what was found in the transcript. Analysis of the themes centred on connecting the themes; listing the themes and considering the relationships between them and translating the analytical themes into a narrative account for presentation. To minimise the uncertainty of interpretation and to promote credibility, different methodological processes were identified, some of which were employed and others discounted.

The criterion of member checking is a process whereby participants review collected data or data analysis and confirm or challenge their accuracy (Johnson & Waterfield 2004). Whilst recognised as an alternative approach to evaluate the worth of qualitative research, member checking was not employed in this study. The process of member checking is questionable and associated with potential difficulties. Poor recall or change of opinion by participants and clients are often associated with this process and potentially limit its value. Furthermore, analysis is based on the collective perspective of the participants and clients and therefore may not be consistent with an individual's perspective, resulting in uncertainty rather than substantiation. (Johnson & Waterfield 2004, Long & Johnson, 2000).

The inclusion of researcher triangulation through peer review was adopted to assist accurate representation, by having the findings reviewed by an expert researcher. In this case the student's supervisors. This provided opportunity for discussion, further exploration and promoted rational thinking and a more reasoned and accurate interpretation. To promote credibility of findings, the concept of reflexivity was adopted to promote transparency of results and reflexivity in the interpretation process. Critical examination of personal assumptions and actions and the maintenance of reflective notes by the researcher also formed part of the data collection method (see appendix 7). This enabled enhanced understanding of the analytical process, researcher interpretations and promotes clarity for the reader (Long & Johnson 2000).

## **2.8 Ethical considerations**

Permission to conduct this single site study was initially sought from the Clinical Director of the BSAC and Coventry University Ethical Review committee. Local research ethics approval was then gained in addition to Research and Development department approval of the Trust.

Two of the most important underlying ethical principles applicable to research are beneficence and non-maleficence (Sim & Wright 2000), and incorporate the tenet: “above all do no harm”. Potential effects on participants were assessed and it was acknowledged that the interview might cause emotional distress as a result of participant disclosure. As a consequence, the researcher identified sources of support through the hospital counselling service and general practitioner. For staff, additional support was identified through the occupational health nurse. As the researcher’s professional role is that of a breast care nurse and this particular study involved scrutiny of the breast care nurse’s role, the above support was also identified for the researcher.

Informed consent implies that the participant possesses adequate information at a level of satisfactory comprehension. This act safeguards the participant’s freedom in their choice to participate voluntarily or not to participate in the research (Polit & Hungler 1999). All participants were informed that they were free to withdraw from the study at any time.

Participants have the right to anonymity and confidentiality (Sim & Wright 2002). The researcher assumed responsibility to provide assurances to participants, that if any quotations were used from their interviews, pseudonyms would be employed to protect their identity. It is recognised that pseudonyms might not adequately secure anonymity, but every effort was made to ensure that the principle of confidentiality was maintained. A list of unique identity codes assigned to the individuals’ names was kept separately and securely. Electronically held transcripts were password protected and hard copies kept in a locked filing cabinet, maximising ethical practice, confidentiality and adherence to the Data Protection Act (1998).

A further tenet central to ethical values is that associated with personal integrity and responsibility to disseminate the research findings. As this study might have implications for future practice, publication in appropriate journals and presentation to stakeholders within the local Breast Screening Unit will be sought.

## **2.9 Summary**

The principle behind this choice of methodology was to explore participants' perceptions in BSAC utilising the kind of research questions that are not easily answerable by quantitative methods. The selected approach was particularly useful in this seemingly complex area. As a researcher working in BSAC in which the research was conducted, the aim was to conduct credible 'insider research' taking into account the opportunities and possible pitfalls of undertaking such a task. A researcher who researches her own organisation offers a valuable contribution to knowledge and practice development through explicit awareness of the organisation, processes and participants involved. Nevertheless it is important to keep in mind the potential issues of validity associated with bias, subjectivity and ethical issues when reporting research findings (Smyth & Holian 1999). This study is a natural continuum of previous studies linked with the BCN in BSAC (Ong & Austoker 1997, Scott 2005). It is hoped that this study supports questions raised in the said researchers work and will assist in informing future practice.

## **CHAPTER 3**

### **FINDINGS**

#### **3.1 Introduction**

Following on from the previous chapter which described the methodological justification and design of the study, this chapter presents the findings of the data generated through interviews and data analysis. Figure 1 displays the conceptual inter-relationships of the categories and themes surrounding the central concept of the BCN role in the BSAC.

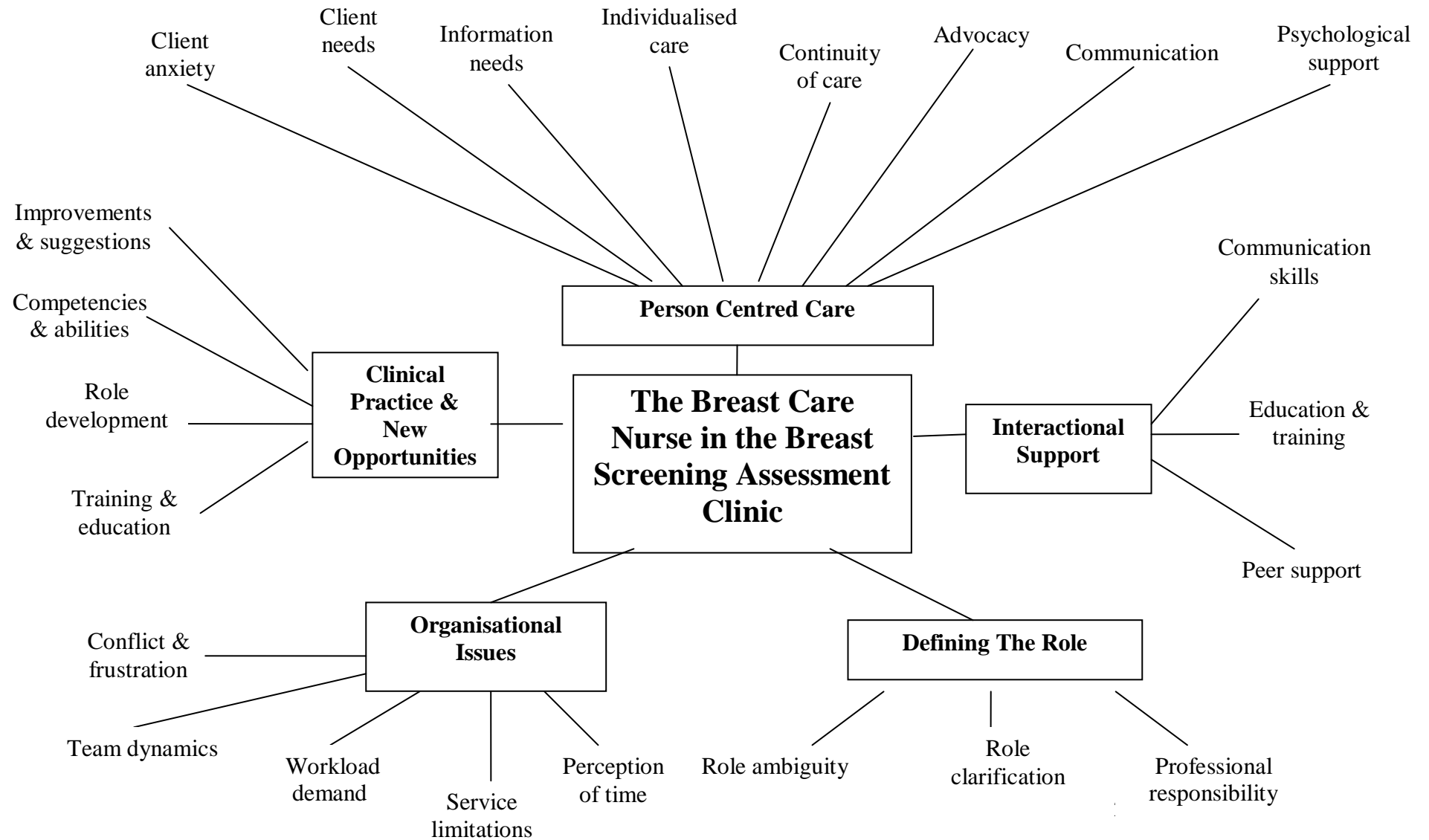
The participants generated wide variations in both their experiences and relationships around perceptions of the BCN role, service delivery and inter and intra-professional working relationships linked to the BCN. Some participants reported positively about their experiences, others declared their ambivalence and some individuals shared their anger and frustration. However, whilst individuals gave account of their personal experiences, it is important to note that common themes and categories did emerge from the transcripts through the analytical process.

Five key themes emerged, (Figure 1):

- Person centred care
- Interactional Support
- Defining the role
- Organisational issues
- Clinical practice and new opportunities

These will now be discussed in detail under the themes as listed.

**Figure 1: The BCN in BSAC**

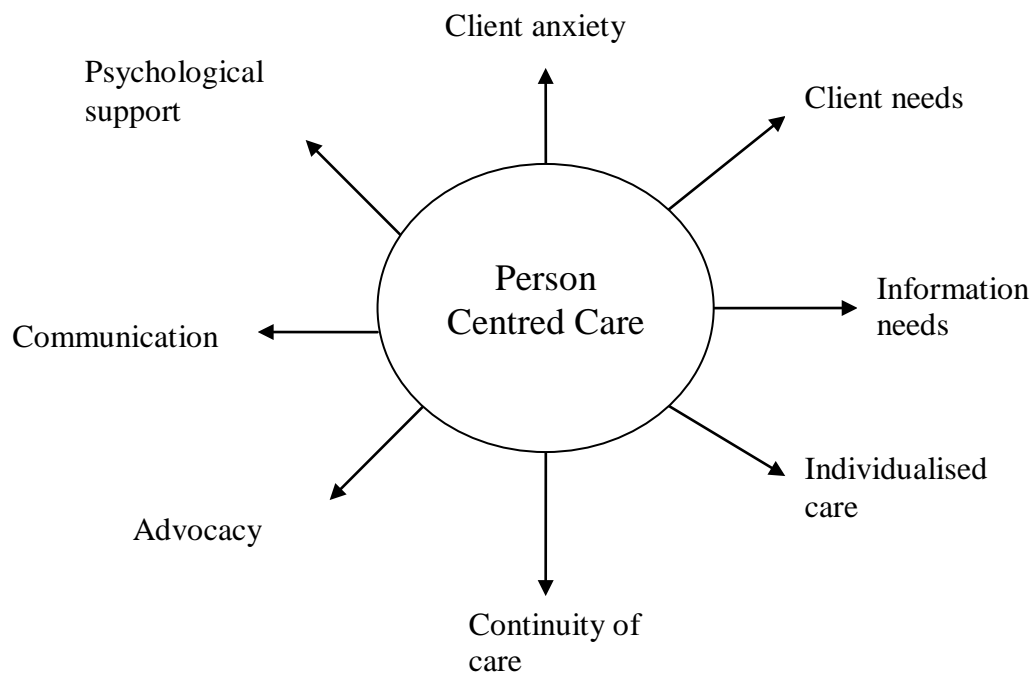




## 3.2 PERSON CENTRED CARE

In this study, Person Centred Care represented a theme defining categories that recognised parameters important to individualism allied to a rich understanding of the individual and their circumstances.

**Figure 2: Person Centred Care structure**



### 3.2.1 Client anxiety

Anxiety is seemingly provoked as a direct result of the screening programme. One of the radiographers recognized the impact of a partner's emotions and the possibility of feeling overwhelmed and confused in the face of anxiety:

It's difficult for them, and of course, you know, they bring a husband or a partner in with them and they very often can't rationalise either, because they are anxious about their partner.

RG3

As recognised by RG3, anxiety was a common finding borne out by most the staff working in the BSAC. In a subsequent statement the BCN acknowledged the impact that the situation had on the clients' behaviour, as the client recalled her experience:

I think that particular lady certainly needed to get across how anxious she was, she was trying to tell me “Please don’t tell me there’s anything wrong because I won’t be able to cope with it. It would be the last straw.” BCN4

In the following autobiographical account, a client expressed a profound personal impact and demonstrated how her raw emotions were mixed with the complexity of thought. The anxiety described by this client appeared to give rise to behaviours over which she felt she had little or no control:

It was absolute, what would I say hell, because I don’t know whether all women think positive, but I am here and I am thinking Oh Gosh, what am I going to do? I have got cancer. You know they wouldn’t send for me, the once was fine, twice, and then having a biopsy I was thinking oh well that’s it I have it. CL1

From the health care professionals’ perspective, the radiology staff alluded to client worry in their statements, acknowledging client anxiety and the need for sensitivity and awareness of client need:

These are the women who are ok and are called back and everything is fine. However, it does cause them anxiety and we have got to be very aware of that when we recall these women R2

### **3.2.2 Client needs**

The client needs category was common to all participants in this study. It is perhaps notable that, from the client’s viewpoint, not all women appreciated the BCN intervention prior to the assessment process whilst attending the BSAC. In this category linked to Person Centred Care, emotional responses appeared to be diverse and different coping strategies were adopted:

I saw two boxes and I said do you want me to fill this, and she said don't bother; she wanted to go and get it over with really. She is not interested in things like that. I just felt I needed, I was looking again, I am one of these that tend to look on the dark side, and think what if it is, and what if.

Yes, it makes me (Husband) feel better if I can talk to people and especially people who have information and they are a bit more knowledgeable CL3 Husband

### 3.2.3 Information needs

This category includes dual practices: that of information between team members and information from BCNs to clients. Gaining relevant client information in the psychosocial context was observed to have positive outcomes for staff as well as clients. This was acknowledged by one of the radiographers, who suggested that feedback from the BCN to the radiology team (following the BCNs pre-assessment consultation with the client) alerted the radiology team to the potentially anxious client:

The only time it is useful is when a lady has told you a problem and then you come and tell us and we are aware then of how to deal with the lady instead of going in and finding out ourselves. Sometimes we have had a bit of a warning if the lady is very anxious, stressed out or she has had something else happen and this has just come on top of it. That is **always very** (*participant emphasis*) helpful. RG1

In this statement, it is apparent the participant was addressing me as a BCN and not as the researcher. For the purpose of continuity the impact of this incident in addition to others and the implications of insider researcher and the research are discussed later in chapter 5.

In addition, as previously stated in chapter 1 there was evidence to suggest the BCN played a pivotal role in providing clients with comprehensive information allied to treatments and procedures in a timely and sensitive manner:

The Breast Care Nurse gave me some leaflets to do with cysts. There was lots of information and feedback which was good. She was very thorough, she didn't just leave me and say go off now that is it. She took me to another room and gave me an opportunity to ask questions if I needed to. CL4

### **3.2.4 Individualised care**

For most of the participants, the emphasis on individualised care was associated with a strong interest in the client's experience and needs. For the BCNs this chiefly meant adopting flexible care to meet specific individual needs:

Yes, because you are thinking of that patient as an individual, treating them holistically you're not just treating their breast. It helps us to prepare the patient and helps their recovery really and I think patients have less problems because of that side of our role

BCN2

### **3.2.5 Continuity of care**

It was apparent that all the team within the BSAC saw the BCN as pivotal to the promotion of care continuity. Emphasis was placed on this approach; promoting relationship building; client confidence and trust:

. ....You are a link, you are there to give that information to the rest of the team and it can also help with the way the other members of the team handle that patient, if they have got particular problems, are particularly anxious, or if they have had a recent bereavement. If the rest of the team are in the know about that, then they might handle them in a slightly different way than if they hadn't got that information at hand.

BCN2

### **3.2.6 Advocacy**

Advocacy was a common theme shared by most of the participants as an important aspect of Person Centred Care carried out by the BCN. It appeared to be integral to assessing the 'concerns of clients' that are not always as apparent to other team members and co-ordinating the care pathway, thereby minimising a client's potential anxiety:

You are another voice for the professionals and for that lady aren't you, because you have been with them from assessment right through to treatment, you have seen what has happened in the BSAC and you are there for them, to speak up for them in the MDMs (Multi disciplinary

meetings) and at the clinic for them when they go to see the doctors. RG1

The above statement demonstrated the BNC role as pivotal, suggesting the client perceived the BCN as a champion and a defender to promote their needs and to colleagues the BCN is valued and respected within this remit:

### **3.2.7 Communication**

In this study, the BCNs suggested that the intervention of the BCN at the pre-assessment interview prior to the assessment process was to appraise the client's expectation of the BSAC on a physical/psychosocial level. This was viewed as an opportunity to assist the process of assessment, utilising coping strategies identified to meet individual needs:

Some want to know why, why have they been called back. Some have got something to tell you, like, "oh well, I had an operation on this particular breast" and that might not be the breast that they have been called back for. BCN3

### **3.2.8 Psychological support**

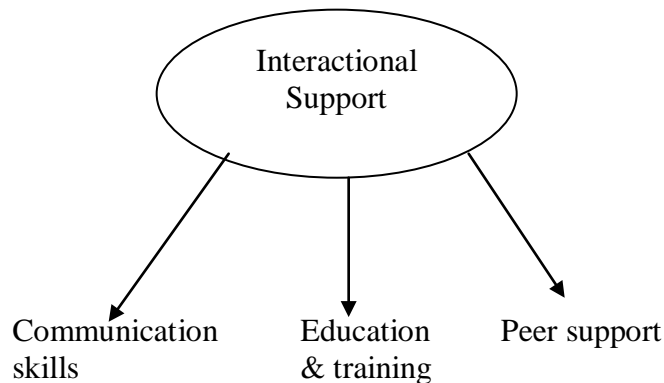
Clinical interventions and routine tests were characterised as opportunities to develop relationships and gain greater understanding and depth of the individual. This view was shared by most of the BCNs and described in the following statement:

I must admit I do when they are doing a biopsy I do tend to get involved with that. I am a hand holder, a blood wiper and I think partly any of the BSAC team can do that to a certain extent, but it gives the BCN an opportunity as well to chat to the patient and just try to suss out the situation a little bit and just through very simple conversation.. ... BCN2

## **3.3 INTERACTIONAL SUPPORT**

In this study, participants and clients talked about three categories to describe their meanings of Interactional Support (figure 3).

**Figure 3: Interactional Support**



### **3.3.1 Communication skills**

Two clients shared their experiences and discussed their expectations of the BCN's support through communication and the benefits to the interaction. The following statement validates an understanding of communication skills expressed by all the clients when relating to this professional group and with it the satisfactory outcomes from the intervention:

.....they have a way about them. They know what they are talking about, they know what words to use, and hopefully that will open somebody to start chatting and let everything out.  
CL2

### **3.3.2 Education and training**

Education and training was a key component within Interactional Support. The emphasis was primarily linked to the education and training of the client in the area of breast awareness, breast health and breast cancer treatments as opposed to health professional training and education. Two of the BCNs identified the opportunity to explore and discuss breast awareness at the post assessment meeting for those clients discharged with benign conditions/normal breasts. Most of the BCNs perceived the role of health promoter as an intrinsic component of service provision:

Maybe to educate someone about being breast aware and health promotion, you know it could be that someone is taking their HRT and do they want to come off it. About

breast cancer management, you know all sorts of things  
really. BCN1

### 3.3.3 Peer support

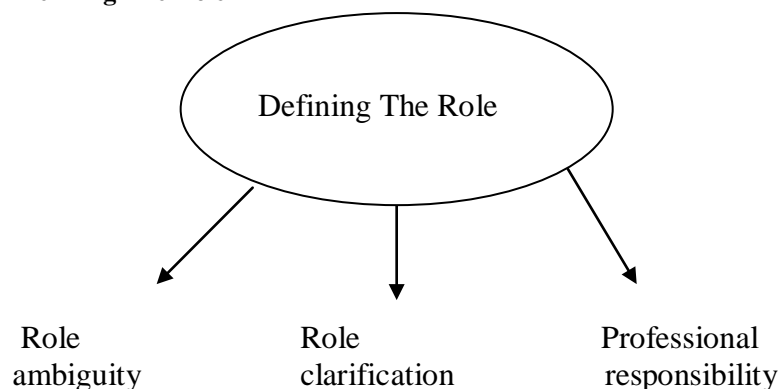
One BCN proposed the activity of peer support be offered and incorporated within the BSAC team. The perception of such a resource appeared to be identified as a transferable skill providing support to all colleagues:

...and may be offering support to our colleagues as well  
within the unit whoever you are working with, a particular  
episode of somebody's journey. BCN1

## 3.4 DEFINING THE ROLE

Role definition was characterised from the following categories. It was noted that role ambiguity and professional responsibility were categories raised by staff and not highlighted by the clients. These issues tend to be hidden aspects of health service provision identified by individuals who work together in delivering services.

Figure 4 Defining The Role



### 3.4.1 Role ambiguity

One BCN's account highlighted her disappointment when discussing her role regarding the additional tasks and advanced nursing practices of the BCN in the clinical setting:

I think one of my biggest frustrations is that at the hospital

where I work I have quite a lot of responsibility and do quite a lot of things and then, when I come **here** (*participant emphasis*), that's not appreciated because they don't know how I work when I'm in my normal environment. BCN4

Differences in expectations and scope of practice highlight further confusion as illustrated by the following statement from one of the radiology team:

I assume that the BCN can do that (give breast awareness advice) but she must be doing it over in the clinic, but I have never heard a BCN do it or give it to a lady. RG1

In the opinion of one of the radiology team, the change in skill provoked confusion even for the radiographers themselves:

Potentially some of the radiographers who didn't want to do higher skills but were still able to train the assistant practitioners started to think "Well, why actually am I a state registered radiographer? What is my role in the system, in the BSAC, that the assistant practitioners can't do?" R1

The implementation of a four-tier structure within the BSAC, (as discussed in Chapter 1), advanced the role of some radiographers. However, whilst potentially beneficial to the BSAC, it has had implications for the BCN where little or no consideration has been given to the impact of change on the BCN role (see 5.2: Recommendation 1):

I think techniques have changed, they've advanced and we are part of that team, but I feel we have still not moved on in terms of the role clarification... BCN1

In this study, BCNs acknowledged that the change in role boundaries had created uncertainty in relation to professional identity, which has for some, ultimately created a breakdown in communication:



But sometimes I feel unsure as to whether I should be a nurse who dabs the patients wound if they are having a biopsy, or, I don't really know when to interject, or become involved

BCN1

### **3.4.2 Role clarification**

The following statement authenticated the role of the BCN and presented a common theme shared by most of the team working in the BSAC:

....it's two roles. Well helping some of the procedures and assisting the doctors and some of the operators for doing some of the biopsies. It's someone who will look at the lady, help you to sort out things the BCNs need to do with them and also communicate with them at the same time, so the BCN is another very experienced person in the clinic.

R1

The unanimous opinion from all participants in this study was that the primary role of the BCN was one of psychological support. The essence of support overlapped into various aspects of the assessment process. The main emphasis of the BCN role was perceived to be for those clients with a potential diagnosis of breast cancer. Most of the participants were of this opinion suggesting that the BCN appeared to be well suited to the role of coordinator and an effective communicator, being the one constant throughout the treatment journey.

For one radiographer it appeared that the role extended to a process of 'ending'. A suggestion identified by many of the participants to 'unwind' and associated with debriefing activities linked to summarising and concluding.

I feel the BCN is finishing the closure, finishing the circle really, because that's sort of the end of the clinic and also I think that the woman's visit finishes on a nice calm note.

RG3

### 3.4.3 Professional responsibility

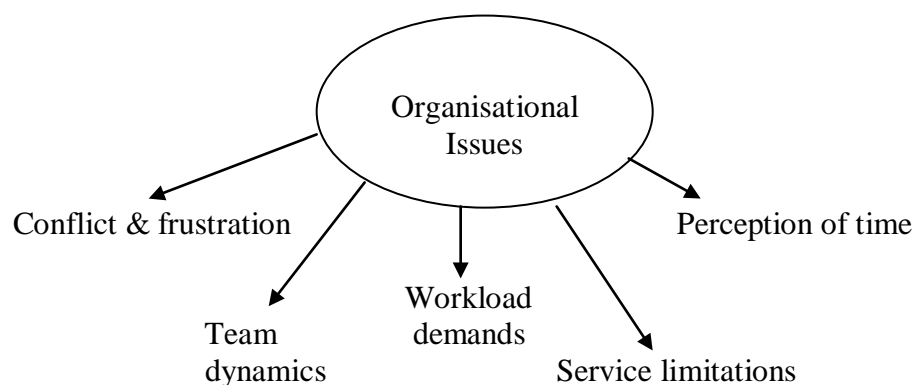
It was evident that BCNs took responsibility for ensuring that their practice was appropriate, taking account of priorities of care according to competency and workload:

Well I think that's what you have got to be careful of as well. I think that if you are assisting people within their roles, freeing them up to do more complex tasks that's one thing. But it's like also, whenever you take on something new, you have to relinquish something and I'm not sure that there are things in my role that I am prepared to relinquish.  
BCN2

## 3.5 ORGANISATIONAL ISSUES

This study identified a number of categories that underlie the core theme of organisational issues, as seen in Figure 5. This study identified that, whilst the team was engaged in a common objective of assessment and diagnosis, issues were raised at a more strategic level both within and beyond the BSAC that impacted on the BCN role.

**Figure 5: Organisational Issues**



### 3.5.1 Conflict and frustration

BCNs identified factors that inhibited their practice:

It just seems a bit hit and miss, you know, that we're here in the clinic and, occasionally, it's "We need you with this

lady” or “We don’t need you” or, there’s no definite plan ...  
BCN4

### **3.5.2 Team dynamics**

A common theme expressed by most of the participants was the shared vision of providing an optimal service for those clients attending the BSAC:

No it’s probably more because we work as a team and we are there for each other and I think we are very fortunate in this unit, I think that we have a superb team R2

### **3.5.3 Workload demand**

The BSAC workload demands for BCNs can be somewhat unpredictable and appeared to underlie the difficulties and conflicts associated with prioritising activities and commitments within the BSAC. This opinion was shared by the majority of the BCNs:

You are listening and watching all the time because you are trying to find out what is going on with a lot of them. There may be a lady who will be reassured and discharged but then, there might be another lady who is going to a stereo core. Depending on the lady who has been reassured and discharged, she might still want to see **you** (*participant emphasis*) and if that happens, well, that happens... BCN3

### **3.5.4 Service limitations**

The lack of established links in the absence of the named BCN for that client within the stated catchment area was very apparent. The following statement exemplifies BCN frustration where client care is fragmented. The BCN suggested that failure of organisational procedures expose the client to disjointed care, potentially brought about by service constraints:

As you know, probably, mine do tend to go on different days and that is where it can sort of fall down, but those that I do see on a Thursday morning that is great. It is a

shame sometimes when they do come back on other days,  
that's when the system breaks down a bit. BCN3

### 3.5.5 Perception of time

In this study, clients acknowledged satisfaction in the time given to them through the stages of the BSAC:

She was very thorough, she didn't just leave me and say go  
off now that is it. She took me to another room and gave  
me an opportunity to ask questions if I needed to. CL4

Conversely, in the following statement, a BCN recognised the problem of devoting  
time to one client and the potential that others may as a result be denied the  
opportunity for BCN intervention, a view echoed by all the BCNs:

..... you might be with one patient for quite a long time,  
and then you might come back and three have been  
discharged and you're not there. BCN3

## 3.6 CLINICAL PRACTICE AND NEW OPPORTUNITIES

Clinical practice and new opportunities were characterised through the following  
categories identified by staff participants.

**Figure 6: Clinical practice and new opportunities**



### **3.6.1 Improvements and suggestions**

The suggestion stimulated primarily by the BCNs, supported the need to further promote the BCN role and the support available to those clients attending BSAC:

Well, whether they could be given something, or whether they could be asked would they like to see a BCN. BCN3

For some of the BCNs the emphasis for role development was associated with improving support and education for the client during the BSAC.

### **3.6.2 Competencies and abilities**

It was apparent that for some BCNs, the skill of delivering potentially distressing information was not just about delivering the information. Their concerns related to an ability to judge client's informational needs and interpretation of that information that would promote understanding:

I just felt that I (a) should have been the one to be doing it and (b) could have probably done it a little bit better. BCN4

### **3.6.3 Role development**

The emphasis for BCN role development centred on improving client assessment, information gathering and an advisory role related to the provision of breast health and awareness:

There's an opportunity for education and promotion of mainly self-examination, which the radiologist didn't always have time for BCN4

Interestingly one BCN supported a more flexible approach to BCN practice

.... I personally never thought that one BCN necessarily needs to be exactly the same as the next, everybody's got their own strengths and skills BCN4

It was apparent that for one BCN, role development was associated with relinquishing other components of her role:

I think the other thing is that whenever you are taking on new roles you have to be conscious about what part of your role you are giving up  
BCN2

In relation to the pre-assessment interview, one BCN felt that the opportunity for history taking would have advantages for those clients who might have medical conditions:

I'm not aware of a formal history taking as part of the assessment process and maybe that's something that we could develop as BCNs if it were appropriate.  
BCN4

Other suggestions in support of further role development included BCN consultation at the end of the assessment process:

I think there's no reason why we can't reassure and discharge.  
BCN4

### **3.6.4 Training and education**

In the category of training and education, one of the participants recognized that the BCN could play the role of educator:

I think you are there to teach us things as well, but we will do the same, like the other way round because of the various courses we have been on.  
RG1

## **3.7 Summary**

The findings from the 5 themes identified, indicate a consensus of opinion and understanding, acknowledging the supportive needs of the client and staff within the BSAC. Linked in with those needs, the proficiency of the BCN can be demonstrated

in their ability to communicate competently. However, there appeared to be some inconsistency in service delivery, at times substantiated by lack of evidence, personal interpretation by individuals and inadequate collaboration within the team. These findings will now be discussed in detail in the following chapter.

## **CHAPTER 4**

### **DISCUSSION**

#### **4.1 Introduction**

The previous chapter presented the findings generated through interviews from the participants in this study. In this chapter I will address the findings and discuss these in turn under the identified five themes.

#### **4.2 PERSON CENTRED CARE**

Wing (1999), argues the concept of Person Centred Care is closely connected and interrelated to a holistic orientated perspective that attempts to relate to the meanings and experiences unique to the individual and their situation. He goes on to imply that the concept of Person Centred Care is defined by language associated with terms such as individualised, holistic, patient and person centred care. McCauley & Irwin (2006) describe a similar concept that of ‘patient focussed care’:

“Patient focussed care is compassionate, is sensitive to the everyday and special needs of patients and their families, and is based on the best available evidence. It is interdisciplinary, safe and monitored”  
p543

The philosophy of Person Centred Care developed out of a desire to base health care provision on a rich understanding of the patient, their circumstances and needs (Price 2006). Nurses describe their approach to care as one that permits patients to get involved in decisions made about practice (Halldorsdottir & Hamrin 1997, Andrews et al 2004). According to Price (2006), this approach is in stark contrast to the medical model, a somewhat prescriptive framework that has the potential of creating competition and conflict between health care professions. Literature associated with person centred care is often linked with nursing. Wing (1999) defines nursing by using the idiom “Person Centred Care” as something nurses do and which defines their theoretical and practical framework. Wing (1999) illustrates this further by identifying a demarcation of the work of nurses from that of other health care



practitioners. This is based on the premise that nurses have a prolonged and relatively intimate knowledge of patients and apply this knowledge to distinguish their practice from that of others. The skill of nursing can also be described as the application of psychosocial and interpersonal skills in addition to clinical activity (Wing 1999). However, the depth of interpersonal skills and the experience of the nurse are deemed greater than that of the clinical activity. The ability to assess client need and intervene appropriately through the process of clinical activity is a skill associated with nursing and underpins the principles of a dynamic and flexible approach, based on the client's situation. In this study, all participants associated the BCN with that of Person Centred Care, which acknowledges care and concern for others in a meaningful manner, and supported by Halkett & Arbon (2006). Participants gave various accounts of what they believed were the traits associated with this view, identifying awareness, skills and knowledge among others as major components. The different categories that participants attributed to Person Centred Care are discussed below.

#### **4.2.1 Client anxiety**

Brennan (2005) suggests that anxiety is a clinical term for the fear of real or objective danger and that fear is commonly founded on the unknown. It is associated with uncertainty and is one of the hardest challenges confronting individuals with a potential diagnosis of cancer. All participants agreed that attending the BSAC created anxiety for clients and this is substantiated by Ong & Austoker (1997). The findings from this study show that women felt that communication was the most stress relieving aspect of the BSAC visit. Furthermore, of the women recalled, 58% were distressed or very distressed. The most distressed wanted further information as to why they had been recalled to the BSAC. These study conclusions are similar to those of Pineault (2007) who also identified anxiety as part of BSAC invitation and attendance.

It is important to acknowledge that the origins of the past influence how we feel, think and act (Brennan 2005). The capacity to respond and adjust to particular stressful events varies from one individual to another and is inevitably dependent on life experiences (Brennan 2005). It could be said that fear is associated with

something anticipated - worrying about the outcome. There is little doubt that waiting for the results of an investigation, when the individual fears a cancer diagnosis can be a very stressful experience.

McDonald et al (1996) reasoned that reassurance for clients with a normal test result is not always entirely successful and can be associated with re- emergence of emotional anguish. This is particularly undesirable as anxiety seemingly is provoked as a direct result of the screening programme and appears to also affect others, notably partners (as identified in this study). It is essential that healthcare staff recognise anxiety of client and partner, rather than simply focussing on either one seemingly to be most anxious. However, much of the research within Breast Screening has focussed on the client's needs, with very little emphasis on the partner and their role, especially within BSAC. Such lack of insight might justify further enquiry within this setting.

According to Price (2006), the practical application of Person Centred Care is central to the strong interest in the person's own experience of health, illness, or need. It is therefore assumed that the nurse works with the individual's meaning of the situation, as well as that presented through a medical referral or other avenues of medicine. It is well documented that recalling women to the BSAC has significant adverse psychological consequences (Heckman et al., 2004). Ong & Austoker (1997) suggest there is a failure to identify psychosocial problems experienced by women. These findings are consistent with many studies exploring health professional's assessment skills at detecting levels of distress in the cancer patient (Passik, et al. 1998, Passik et al. 2001). The common assumptions that deter expression vary from lack of confidence and skill by the health professional, lack of time and raising issues perceived not to be the responsibility of the health professional (Brennan 2005).

There was a lady today who was perfectly fine, she was a technical recall. She had asked to see the BCN beforehand so I talked to her about why she had come back and she ended up telling me all about the fact that she's depressed, she's got difficulties at work,

BCN4

It can be argued that the BCNs' have a different perspective, recognising the potential physical and psychosocial aspects that may have a significant impact on the client's adaptation to such an event. The BCN appeared to acknowledge the impact that the situation had on the woman's behaviour and on what aspects the client was focussing. It is my interpretation that through exploration and discussion with the client the BCN was able to offer flexibility and adopt a position of care and support as part of the service. It could be suggested that attendance to BSAC may have had a compounding effect and with it the associated anxiety affecting the individual's present circumstances. Whilst anxiety is acknowledged in this study as common to this client group, there may be the opportunity to reflect this in the invitation letter and allow clients to identify their own levels of anxiety on attendance to the BSAC, thereby identifying the high-risk group for potential BCN intervention. (See 5.2: Recommendation 2). Providing appropriate and timely support during assessment at the BSAC might provide greater benefits to the client (see 5.2: Recommendation 3). However, it is beyond the remit of this study to assess the potential benefits of this and therefore warrants further investigation

Arguably, it might be suggested that the benefits to the BCN acquiring specific knowledge and understanding of clients within this clinical setting were to allay client anxiety. However, under the limitations of the present system and the lack of formalised client anxiety assessment, I would argue the BCN is unable to provide timely support and optimise client care.

#### **4.2.2 Client needs**

It appeared that not all clients wanted to be active collaborator in healthcare, nor receive detailed information. Although a client might decline involvement from the BCN, it does not negate the client's ability to ruminate and worry, leading to anxiety and distress and a potential missed opportunity. It could be interpreted that some clients adopt avoidance coping strategies to circumvent their needs as a response to fear, an approach that requires sensitivity and respect from the BSAC team. In one account, the husband's needs were not acknowledged. It might be inferred that, overall, women's needs appear to be central to the provision of a compassionate

BSAC experience, negating the individual needs of the accompanying partner. However, through knowledge and understanding, a partner may be empowered to give support and comfort during a potentially vulnerable time.

One of the clients expressed her thoughts from an emotional perspective. This appeared to be a recurring theme, with the majority of clients expressing the necessity of needing time, privacy and a carer who conveyed an empathic, sensitive approach.

Yes, I was so certain, and that is why it was great to come out of there, have a breather, the BCN comes into you, you sit there have a good cry and nobody cares, only you (BCN) care, you know it was good. CL1

Interestingly, the client utilised the **post** assessment discussion as an opportunity to explore other areas of her life which co-existed at the time of attending BSAC. These concerns appeared to influence her thoughts, feelings and behaviour's impacting on her everyday activities and on close members of her family. It demonstrated the client's appreciation of the opportunity for privacy and reflection. This interpretation suggests that for some clients recall to BSAC did have a profound effect on the individual and therefore cannot be underestimated.

The perspective of a BCN, however, showed less appreciation of post assessment discussion. There appears some confusion and a lack of understanding by both the BCN and the client.

..... the patients have already listened to a lot of information, they've listened to other people's opinions and you are almost an add-on and I mean, sometimes you can get the feeling from patients or from their relatives, well, "why I am seeing this one now? I've seen all the others. They've all told us what's wrong. What's valuable about this person?" BCN4

There was perhaps an assumption that on occasions during the assessment process, needs were based on conjecture not determined by the client, but by individuals within the team. The previous statements suggested that formal closure at the end of

the assessment process provided a positive conclusion for some clients. This however, may not be so for all clients and promotes a need to focus on delivery of care determined by client expectation and need.

### **4.2.3 Information needs**

This category discussed a twofold theme: client information exchange between team members and information from BCNs to clients. From the radiographer's viewpoint, it suggested that insight prior to clinical assessment was beneficial. Consequently, such knowledge might have appeared to modify the radiology team's behaviours and assist the client through the process of assessment, supporting the philosophy of person centred care. This would suggest such activity aims to assist the radiology team to manage the client with greater knowledge and understanding and thereby provide a more attentive and sensitively driven service

The process of communicating relevant physical and psychosocial client information between the professionals was not addressed in this study. However, in the light of present procedures and lack of guidelines, a clear structure that defines how information is transmitted throughout the team, from the BSAC to the symptomatic outpatient clinic, is imperative for the quality of care delivery. (see 5.2: Recommendation 3).

The provision of information to clients was felt by the BCNs to be integral to the BSAC process. Specific information related to wound care management, contact details, breast awareness, benign breast conditions and, where appropriate, treatment options. In addition to making the information available, the BCN identified the importance of how that information was conveyed. Thus the BCN, with her expertise, especially as an experienced communicator, recognised the complexity of this process and the necessity to deliver the message clearly, simply and in a timely fashion.

One of the BCNs acknowledged that during the radiologist's consultation some clients were extremely anxious and when coupled with time constraints of the

radiologist, created an environment that might not have been conducive to the assimilation of potentially complex information.

Information giving is a big thing, because where patients are highly anxious and the doctors probably got five minutes to spend with them and tell them things, most of the time they (clients) don't absorb the information. BCN2

These findings are further substantiated by Brennan (2005), who advocates that clinical appointments are often highly stressful, associated with uncertainty creating poor environments, inhibiting meaningful information exchange. This might imply that patients may not find it easy to convey their own feelings and thoughts and to understand and recall complex information at such a time.

#### **4.2.4 Individualised care**

Descriptions in the literature suggest that individualised care requires some background knowledge of the patient, which nurses use to devise care that treats each person individually (Wing 1999). It is considered to be a significant characteristic of nursing care, a commonly held belief by nurses and users of the health service (Radwin & Alster 2002). According to this study, individualised care was epitomised by the following statement from a BCN:

Thinking of the patient holistically, bearing in mind their social background, their spiritual well-being and things like that. BCN2

A client summarised this approach and acknowledged that other aspects of her life may have impacted on her ability to cope with what could be seen as yet a further potentially stressful event. From the client observing the ability of the BCN to connect with her and acknowledging those aspects specific to the individual, created a positive effect. One client described how this connection affected her:

Like you know family, and everything because she knew I hadn't been that well, and it felt good to know that they are not just there for breast support. CL1

These comments emphasised the dynamic and flexible nursing approach, based on the client's situation and how BCNs, ideally, want to be involved within the BSAC. In other words, the BCN was proactive in her search to gain greater understanding of the client's world; the social context of the person and customise her approach to meet those needs. Whereas the majority of the radiology team acknowledged the client as an individual, there was little evidence to illustrate this. The main emphasis of individualised care was associated with the remit of the BCNs. It might be argued that the BCNs were in a unique position to provide time and utilise coping strategies and adaptive behaviours to assist the client during their experience of the BSAC. Berg et al. (2005) embraced this philosophy, suggesting that the need for nurses to understand is essentially altruistic and therefore their goal is to promote understanding and modify interventions to assist the client.

#### **4.2.5 Continuity of care**

Continuity of care was identified as another component of Person Centred Care. The client accounts were based on their supposition of need through the process of assessment as identified in the following statement:

It would be ideal if you had the same BCN who knew you all the time, it would be nice if you started off with somebody and you finished with that somebody. CL1

CL1 validated this acknowledging the importance of establishing a relationship built on good communication and a caring attitude. This suggested that forming relationships involved shared histories that shape the client, allow for expression of feelings that encouraged greater understanding, when wishes or needs were expressed during potentially stressful situations.

..... I think it is the same with the nurses... you feel they care which they do, rather than, "oh I have got to go to another one" and if I wanted to say something I wouldn't say it. Because, why should I, I have already told this other nurse and I wouldn't feel that same bond with some else. CL1

It was interesting to note that the client described the nurse's actions as one of caring, however, did not expand upon this concept. Brilowski & Wendler (2005) suggest that there are five attributes to caring within nursing:

- *Relationship*: the nurse identifies the needs of another due to disease, crisis, or an ability to engage in self-care and often described as a companion on an illness journey
- *Action*: doing for, or being with the patient
- *Attitude*: promoting a positive approach to be perceived as caring
- *Acceptance*: seeing the person behind the patient, validating patient expression
- *Variability*: Changeable dependent on experience

This is a view supported by Hartick (1997), who characterises the caring relationship as one that embodies a concern for others, in a manner that acknowledges and supports health and healing, through a meaningful experience. This is further supported by Liebert & Furber (2004), who found that 88% women in their study rated continuity of care as a major benefit, 77% reported further advantage from ongoing contact with the BCN and 96% felt that the BCN was skilled in conveying their needs to the doctor in the treatment team. The benefit is demonstrated in a statement from this study:

Well we did have a client not so long ago; she had had a terrible time. I think she had lost a child and a son and then lost her husband and she was very vulnerable and she almost certainly had got a cancer and just the fact that the consultants knew, they don't barge in and say "well who's at home with you", you can gently skirt the issues rather than going in feet first and asking very difficult questions that she was very sensitive to. I just think it's a kinder and gentle way of dealing with people.

BCN2

The client on the cancer trajectory is experiencing existential changes involving the lived experiences of uncertainty, vulnerability, isolation and discomfort and with it redefining roles and goals concerning life and health (Halldorsdotti & Hamrin 1997).



From the BCN perspective, it was important to understand the client's own life experiences, in anticipation that the consultation and ongoing care with the doctor and BCN were conducted with competent care and compassion. In the previous quotation, the BCN focussed on the client's bereavements and the potential loss of close family who would normally have provided support and help to cushion the client from the threat of a potential breast cancer diagnosis, as well as facilitate coping and adjustment. This was seemingly an important and valued aspect of client care shared by the radiologist:

I have always firmly believed that, you know, wherever possible it should be one person that sees them right the way through. R1

However, whilst acknowledging the importance of one BCN following the client through the BSAC to the outpatient results consultation, this is not always possible thereby fragmenting care delivery. It is my interpretation from R1 that, in the absence of the representative BCN for that area, the BCNs have well-established communication systems with other BCN colleagues and therefore the option of an alternative supportive resource, would provide an acceptable substitute. It might be argued that this study found little or no reference to established links in the absence of the named BCN and the provision of care for that client within the stated catchment area. However, all the BCNs were keen to voice the importance of providing continuity of care, especially for those clients who may require surgical intervention beyond the remit of the BSAC. As a practising BCN in the same BSAC I would question the validity of such a system that does not, in its present format, offer potential benefit to the promotion of continuity of care both for the client and the BCN (see 5.2: Recommendation 3).

#### **4.2.6 Advocacy**

An advocate is someone who intercedes on behalf of another (Collins Concise English Dictionary 1992). Advocacy is a process of information sharing, promoting patient decision making and encouraging the realisation of that decision by offering support or resources to fulfil their intent (Wells 1986). Frequently, nurses act as

clients' advocate when clients are faced with making decisions or exercising choices. The skills of advocacy include mediating, coordinating, clarifying, and resolving conflict. The role of advocate has been pioneered by BCNs for those diagnosed with breast cancer and has been evaluated by Maguire & Faulkner (1988) and Watson et al., (1988). Furthermore, advisory documents such as Forrest (1987) and BASO (1998) endorsed the supportive role of an appropriately trained BCN to participate in information giving, decision making and psychological support. The BCN appeared to facilitate this by creating a culture of caring that addresses the needs of the client, family and healthcare team and focused on an appreciation for individual differences and an understanding of the contribution that each person brings. In addition to skills of advocacy, is the need for specialised clinical knowledge and operational day to day awareness. The BCN may find herself functioning as a mediator, facilitator of processes and feedback representative to name but a few (Copp 1986). The author suggests the combination is an absolute necessity in order to fulfil the duty owed to patients for justice and beneficence.

It is my interpretation that such awareness of advocacy enables the BCN to anticipate a need to adapt the care delivery and foster an environment that promotes best outcomes leading to improved quality of care and client satisfaction. The following statement encapsulated this philosophy succinctly:

Well it's going back to the things like the multi-disciplinary team and discussing patients-quite often without inside knowledge about certain things that the doctors don't always pick upon, or the radiologist don't always pick up on. Then I think something might be important and we take that back to the MDM (Multi disciplinary meetings). Without us that would be missed and that quality would slide I think.

BCN2

Brennan (2005) suggests that the very nature of relationships within the arena of health care is not perceived to be always truly equal when considering the doctor-client relationships. It is therefore apparent that clients may feel compromised in the art of autonomous communication, hence the need for advocacy to convey the client's viewpoint. This is further supported in the following statement:

I think that's very important that there's a BCN there that can see it from the patient's point of view, because there are occasions when the team can get a little bit carried away in the pressure to get things done and things sorted. I don't think it happens very often but there's a need for someone there that has a different view.

R1

Although R1 did not elaborate in greater detail on the process of assessment and diagnosis, it could be interpreted that R1 entrusted the BCN with the role of advocate and perceived the BCN to act as agent acting in the client's interests. It might be inferred that this responsibility assumed the BCN to be assertive, competent and valued by the team in the need to problem solve and provide enlightenment. It is acknowledged that the preceding quotations centre on patient advocacy relating to those clients with a potential threat of breast cancer. However, the role of advocacy was also recognised in those clients with normal or benign conditions who may also feel compromised in achieving satisfactory outcomes through the process of assessment in the BSAC.

#### **4.2.7 Communication**

Communication relates to support and consideration through the process of information flow between individuals and is deemed to be the non tangible elements that make the difference to care delivery (Brennan 2005). In particular, it related to the client's emotional response to being recalled and suggested that the need for information increased for clients who presented with heightened anxiety. This is a similar finding to work undertaken by Ong & Austoker (1997), which identified the need for communication in the BSAC. Furthermore, clients who had the opportunity to talk in private with a BCN prior to assessment were more satisfied with the information communicated to them than where there was no BCN intervention, or where the BCN did not routinely provide an opportunity to talk (Ong & Austoker 1997). The option of discussion was not highlighted as an important factor by the clients themselves, but is a preferred practice adopted by the BSAC participating in this study. However, there were times when a BCN may have not had an opportunity to meet with a client prior to assessment. This is illustrated by a BCN who expressed her concerns:

When I did meet her I could tell from her body language and the way she was communicating that it would have been more valuable to her to perhaps have had an opportunity to speak to me a bit earlier. BCN4

Here the BCN believed that the client's emotional state was coupled to the lack of timely delivery and quality of communication. The BCN felt that giving the client an earlier opportunity to talk might have provided an opening to assist the client to identify and describe her concerns and thereby minimise anxiety.

The skills of communication were broadly based on the application of counselling skills that are expected of a BCN working at this higher level of practice. This is discussed later under the theme of Interactional Support. However, the following statement exemplified the essence of the facilitation process in gaining insight:

So just using the skills that we've been taught to pick up on anything they want to put across, or maybe don't want to put across, but we can tell it's bothering them. BCN4

Although the BCN considered this to be part of her role; it is my interpretation that lack of resources and unrealistic expectations may have impacted on care delivery. In today's economic climate realistic work load priorities and collaboration are essential requirements to ensure appropriate and timely BCN intervention. This is explored further in discussions of Organisational issues.

#### **4.2.8 Psychological support**

The link between Person Centred Care and psychological support within the context of this study was associated with the impact of BSAC on the client and their perspective and how healthcare staff provided optimal supportive care. It is my interpretation that the BCN's involvement during clinical procedures was a deliberate and conscious act to involve herself in the client's journey. Through the assessment process, it was perceived there was the possibility for relationship growth and greater opportunity for understanding an individual's state of mind. As a consequence, the

BCN believed that through this knowledge she was able to engage with the client and provide meaningful support:

She (BCN) held my hand during the biopsy, I am petrified of injections. Of course a woman of 60 something lying there crying and she is holding my hand. The thought of a needle absolutely horrifies me. CL1

....but she was there all the time, you know, rubbing my head, holding my hand, and telling me not to worry. CL1

It is very apparent that the client was gripped by fear at the thought of such an invasive procedure. It might be argued that the sense of touch and sensitive approach had a positive impact on the client. Understanding the effects that fear had on the individual assisted the BCN to better manage the situation and minimise anxiety. From a radiographer's viewpoint, the clinical procedure was enhanced by the presence of the BCN in her capacity to support the patient, as illustrated by their experience. She felt that not only did it make a difference to the client's experience; it also assisted in the expeditious approach to completing the task, thereby potentially impacting positively on overall performance:

They are essential for that because they know for stereo cores particularly, if there is a practitioner doing it and a radiographer in there doing the computer work. To have a BCN there really, just concentrating on the woman and keeping her at ease... I mean there's a definite difference if you've got a BCN. RG3

This suggested that the presence of the BCN during clinical procedures appeared to be potentially multifaceted, providing the opportunity to develop a relationship with the client and minimise client anxiety. This was supported by May (1992), who suggests that nurses aspire to come to know their patients as more than an object of clinical attention through which clinical procedures are undertaken. Such exchanges identify personal traits and symbolize patients as psychosocial beings with needs, motives and problems. To deliver person centred care, the nurse must come to know the person, their anxieties, fears and needs (Davis & Kumar 2003).

## 4.3 INTERACTIONAL SUPPORT

### 4.3.1 Communication skills

The BCN must be able to demonstrate excellent interpersonal skills to support clients and develop a relationship that is meaningful and brings about tangible and valuable benefits (Royal College of Nursing 2007). Ordinarily, communication skills are perceived to be an integral component of the BCN role utilising highly refined skills and knowledge to assess and deliver care in a supportive environment:

It's the way we look, the way we react, our body language, our voices, the way we speak. In terms of not to come in quite brash... it's our verbal and non-verbal sort of communication.  
BCN1

This opinion was further supported by a radiologist who attempted to articulate the differences among the other team members in the BSAC:

BCNs ask the same type of questions and try and get the same sort of feedback which you don't necessarily get from the other professional groups.  
R1

The preceding statements suggest that there was an acceptance, that a core component of the BCN role is one of Interactional Support. As such, Interactional Support is recognised as integral to promoting client expression and meaningful communication, thus providing optimal care, consistent with meeting client needs. In addition to the BCN's skill of Interactional Support, is the wealth of knowledge pertaining to breast conditions and their treatments (RCN 2007). Combining these tools I would suggest promotes the BCNs as a rich resource to the BSAC team. Furthermore the presence of a BCN, during the medical consultation process, plays an important role in supporting the client through the course of information sharing and ongoing care (Brennan 2005). As previously stated in person centred care, it is sometimes difficult for a client to question the opinion of the doctor because they may feel unqualified to challenge a diagnosis, therein creating potential client dissatisfaction (Brennan 2005). A client alluded to this in this study, highlighting her lack of confidence and inability

to probe and seek greater insight and knowledge. Coupled with that is the conflict of work pressures in this BSAC to complete the assessments in a timely and efficient manner, which may at times, have led to compromised doctor/client relationships. Terms like ‘doctor’ and ‘patient’ incorporate widely held beliefs about who does what to whom, who is the provider and the recipient, who has power and authority and who does not. Society is responsible for these internalised assumptions that people bring with them to their consultations (Brennan 2005).

Overall, health professionals have a tendency to be over-directive in their technique of interviewing. Interruptions and closed questioning inhibit disclosure and minimise client expression and probing (Brennan 2005). These styles of communication may represent a hurried or stressed health professional or one who lacks an empathic understanding. The outcome of such action amounts to failure of communication and the rationale for advocacy as identified in person centred care (Brennan 2005).

Within the context of the BSAC, I would suggest that the presence of the BCN, with her knowledge of breast disease, the complexities of investigations and treatment options, is well placed to deliver quality information. One implication is that the BCN complemented the work undertaken by the radiology team in the BSAC:

..and I think you can find out really just by being there the type of person, whether you feel that, yes, they (client) have taken in all that information or whether you just need to spend a bit more time with them going over things.

BCN3

In contrast, a radiographer shared her experience of client reaction and suggested this was potentially influenced by the initial sense of relief of a benign breast diagnosis and therefore warranted no further explanation. Such optimism should not, I believe, be taken at face value when determining client’s response to their assessment experience. It became apparent that for one individual the option of promoting further contact appeared to have been overlooked. It may be questioned whether it is really appreciated how clients have understood the information communicated to them and how they respond to it emotionally. The implications of Ong & Austoker (1997)

study identified ways of improving the delivery of results by verbalising the information with support of the BCN. Utilising techniques of simplification, repetition, explicit detail and opportunity to ask questions, supplemented by written information and contact details encouraged good communication; a finding substantiated by Pineault (2007).

Although one of the radiology team expressed a reservation for those clients who leave the clinic without BCN intervention post assessment, they observed that in their judgement, there had been little or no experience of negative feedback from clients following the attendance at the BSAC. Consequently this appeared to legitimise the present approach as satisfactory: that the client with a normal / benign result consultation is discharged by the radiology team followed by a written follow up letter (Ong & Austoker 1997). As one client in this study did not receive her follow up letter, it is important to point out that this method of communication needs to be consistent with the expectations promised to the client and deficiencies are acknowledged and addressed appropriately.

#### **4.3.2 Education and training**

According to Fawcett (1992), health and health promotion is an integral part of nursing designed to meet the needs of individuals. The aim of health promotion is to support individuals in their need for knowledge and to offer practical assistance and stimulate healthy living (Berg & Sarvimaki 2003).

R1 however, disputed the benefit of breast awareness at the time of BSAC attendance. It appears, from the radiologist perspective that the visible focus within the BSAC is centred on assessment and diagnosis, with breast awareness perceived to be a low priority. A view also shared by one of the radiographers. Conversely, the majority of clients identified the need for breast awareness at this time, recognising their lack of knowledge and understanding and their willingness to participate in educational instruction. This is supported by the Cancer reform strategy (DH 2007) which acknowledges the increasing prevalence of cancer and need to focus more on prevention and commitment to screening and early diagnosis. There is potential scope for the development of a nurse led clinic offering a well women service as part of



BSAC. Such activity would require consultation and collaboration with all interested parties, but nevertheless opportunistic in offering a comprehensive breast care service (see 5.2: Recommendation 3).

In addition to Ong & Austoker's (1997) work, a study by Scott (2005) supports findings that knowledge relating to harmless breast conditions was considered by the clients to be a continuing prerequisite. I suggest that this is a common phenomenon expressed by many women and the lack of such knowledge arguably may result in non-compliance and therefore possibly disempowering the individual to be confidently breast aware. The following statement reflected the opinion of the clients during their experience of the BSAC:

Oh definitely yes. Because you would be amazed there are a lot of women who don't know how to check their boobs properly and what to look for.....

CL2

I would advocate that the BCN is in the prime position to offer this well women service, dependent on client need. Notably, in this study, it was perceived by the BCNs themselves that they have the knowledge and skill and this is reflected in the activity performed by BCNs in the symptomatic outpatient breast clinic. At this clinic, BCNs work closely with the breast surgeons in promoting and advising breast awareness and enhancing health promoting behaviours that empower patients. Therefore it seems reasonable to transfer these skills to accommodate the needs of the client group within the BSAC setting:

Breast pain and benign breast disease. Absolutely, we see this in the symptomatic clinics

BCN2

The following account implied that as a consequence of BCN intervention, the client appeared to gain greater insight and understanding of the true meaning of breast awareness. This is in stark contrast to the concept of breast self examination, a potential daunting practice with identified risks of increased anxiety, uncertainty in technique, guilt and false positive results, to name but a few:

I just talked about knowing what was normal and then if something was abnormal how it would hit you and looking at being more body aware. She felt that she could cope with that approach, whereas her previous idea of what being breast aware was strictly examining herself and she just said when she came to do it she just couldn't do it. But she could cope with being more bodily aware really and just examining herself in the shower and she felt better about that.

BCN2

It can be argued that the potential contribution of the BCN is far greater than is presently exploited and widely acknowledged and that the BCN's dual interpersonal communication skills and breast knowledge provide an explicit combination of expertise to deliver a sensitive and rewarding outcome for the individual and professional alike (see 5.2: Recommendation 4). Additionally, it must be remembered that breast cancer in the Western world has a high mortality and that there is a duty for all health professionals and those working in the field of breast care, in particular, to improve and promote breast awareness (DH 2007). In the light of client response, I would suggest the BSAC is uniquely placed to provide health enhancing advice and this warrants further exploration.

### **4.3.3 Peer support**

Peer support is a strategy employing high levels of interpersonal communication skills aimed at providing a supportive relationship between equals. It is an activity within nursing which promotes reflection through active listening, assist problem solving and maintain personal and professional wellbeing REF. Dealing with potentially anxious clients can be stressful and at times very challenging. The suggestion of peer support was therefore proposed by one of the BCNs. Interestingly, while the notion was supported by one of the radiology team, there appeared to be a sense of patriotism restricted to addressing peer support within her own peer group:

Yes possibly, possibly. I don't know whether people would use it formally I have to say. We are a bit I won't say cliquish; we tend to keep within our own regimes to a degree. I think there will always be a bit of us and them sort

of situation, although I must say nowadays the margins are  
much more blurred, which is nice R2

From the perspective of the BCN the following statement demonstrates how peer support provides useful reflection and new learning:

... how to respond to challenging questions from an  
individual or dealing with anger..... BCN1

In the above statement, there was a suggestion that peer support can have a positive effect. However, this is solely dependent on the individual. Dealing with emotionally charged individuals may have stressful consequences for health professionals working in the BSAC. Sharing events and incidents may provide enlightenment and rewards for both parties. Historically, peer support has been promoted within nursing as an area of good practice to facilitate new learning and improved development.

## **4.4 DEFINING THE ROLE**

The traditional role of the BCN in BSAC was implemented as a result of the adverse psychological consequences associated with clients attending it. Ong & Austoker (1997) and Pineault (2007) have demonstrated that recalling women for assessment creates anxiety and distress for those clients who may then be confronted with a breast cancer diagnosis. From work undertaken by Scott (2005) the same questions were raised relating to the role of the BCN in BASC as identified in this study. In person centred care, I have acknowledged facets that are perceived to characterise the BCN. However, there is still a degree of role ambiguity, which has created confusion among the healthcare professionals working in BSAC.

### **4.4.1 Role ambiguity**

Traditionally, within the symptomatic service, BCNs support clients with benign breast disease and those at high risk of, or who have been diagnosed with breast cancer and their carers. The BCNs provide information; assess physical and psychosocial recovery, offer emotional support and offer practical advice through the

treatment journey. The BCN's scope of practice spans other clinical spheres external to the BSAC, including outpatient clinics and inpatient care, which demand collaboration with various health professionals. BCNs working in the BSAC normally hold the title of CNS. The minimum qualification for a CNS is that of a registered nurse. However, most CNSs have acquired first degree qualifications or are pursuing additional educational courses, such as master's or PhD programmes.

Since the introduction of the CNS in the 1980s, there have been variations and diversity in role function and, as consequence, inconsistencies in practice and role development. Advanced nursing practice has, in accordance with demands of the working environment, been responsive to changing needs of the health care. The RCN (2007) has provided a framework and guidance for nursing performance, providing opportunities for the acquisition of new knowledge and skills and managing professional development. This has placed emphasis on new opportunities and greater autonomy, developing new ways of working in response to changing health care. As a result there has been a shift with increasing levels of clinical autonomy for some BCNs that has not been recognised by BSAC.

It is my contention that role ambiguity has created job dissatisfaction as highlighted by BCN4 in chapter 3. As a consequence she felt unsupported within the BSAC and hence unable to utilise clinical skills developed beyond this setting. Lloyd Jones (2004) suggests that advanced nursing practice has created further role ambiguity and consequently a negative effect resulting in lack of job satisfaction, demotivation and inhibition of role development. Such uncertainty of others roles, expectations and responsibilities are characteristic of role ambiguity and were evident in the following statement. One of the radiology staff appeared to associate the BCN role with that of the radiographer at the pre-assessment interview, in the BSAC investigations:

I don't think there's an appropriate necessary **economic** use of your time to be running round telling women that "We don't know what's going on but we're going to do the following tests" when the radiographer is virtually going to **do** those tests, and **can** do that just as well. R1

This suggestion acknowledged role repetition, a view supported by some of the radiology team. However, as expressed by the following statement the remit of the BCN, I would interpret is more than advisory:

...you need somebody rather than the lady who takes the x-ray who informs you its nothing to worry about; I know they can't tell you. The anxiety of the wait and the BCN is there they try and reassure you which is good. CL1

Where there was recognition of heightened anxiety prior to or during a clinical procedure it was felt the BCN played a vital role. The primary purpose was to establish a rapport, minimise anxiety and build on relationships that promoted ease and transition through the assessment process. It is apparent that role ambiguity and relationships with colleagues are seemingly important factors for consideration when attempting to implement practice and new developments. Consequently, to reduce ambiguity and negativity it is suggested that objectives and role clarification are identified and communicated to relevant key stakeholders to support practice and development (Lloyd Jones 2004). Documenting the findings on the role and function of the BCN in the BSAC in this study is essential for further legitimising their practice and publicising the contributions BCNs provide in the BSAC.

#### **4.4.2 Role clarification**

Role clarification is linked to role definition and seeks to provide insight, recognising and acknowledging personal meaning of the BCN role. A participant took this a stage further in their detailed account by identifying the knowledge skill of the BCN beyond the remit of the BSAC. Here the emphasis focused on the treatment trajectory and the potential questions that clients may pose in preparation for the cancer journey:

I mean BCNs can often be much more practical about answering those questions that you don't really want to go into in the first five minutes but "How long am I going to be in Hospital?" "What am I going to do about the dog?" "How long is my drain going to be in?" etc. etc. that's what nurses do as part of their job. R1

Through the attainment of knowledge and skills, the BCN is an experienced nurse with a wealth of knowledge pertaining to breast health and breast disease. The BCN is available to impart advice, demonstrate breast awareness, identify and explore attitudes and behaviours such as fears and misconceptions that potentially may disempower clients in the practice of breast awareness. From the perspective of the BCNs, this was felt an appropriate role. However, resources necessitate further discussion and this will be addressed in Chapter 5. This specialised knowledge also provided a foundation for those with benign or normal breast results. As suggested in Chapter 3, the BCN role provided an opportunity for a reflective composed approach to completing the assessment in the BSAC. However, it is important to mention that none of the clients in this study identified this specific facet as an important requisite during their attendance at the BSAC. Nevertheless, a client did respond in a broad contextual manner, which reflected the generic opinion of other clients:

It would be fairly clinical for me. The importance of the BCN is not just clinical it is the whole thing really. CL4

This would suggest that the BCN provides a supportive element, the client defines it as ‘not just clinical, it is the whole thing’, but does not elucidate further. Nonetheless, I would interpret this in the context of the intangible aspects of nursing, which conveys individualism that appears to be ethereal, though associated with that of nursing (Price 2006). According to Ong & Austoker (1997) and subsequently Scott (2005), the role of the BCN in the BSAC is fundamentally related to psychological assessment, provision of information and ultimately care. These findings are replicated in this study, adding to the evidence to support best practice.

#### **4.4.3 Professional responsibility**

The issues pertaining to the category of professional responsibility are derived from the discussion and debate of role definition and the need to carry out duties within the standards of practice as directed by the professional bodies. One of the concerns that relates to practice is accountability. Interestingly whilst core skills were referred to these were not described, or attributed to the professional groups within the BSAC team. As yet there are no core competencies within BSAC to define the set of skills and tasks expected of those BCNs working in BSAC:

A lot of time has been spent, not deliberately but over time into working into this principle of core values, core skills, almost understanding and trusting, every member of the team, understanding and trusting that all the other members of the team can not only do their job but be part of the job that they perceive as **theirs** (*participant emphasis*) to a reasonable standard and everyone's comfortable....

R1

The concept of collaborative performance was a factor in establishing and maintaining professional working relationships within the team. However, there were times when effective team working was hampered and objectives difficult to achieve when specific performance problems were identified. A BCN expressed her concern for a colleague's practice and demonstrated her confidence and ability to take responsibility under pressure when challenged with a potential clinical incident. The BCN felt she was in a position of influence and emphasised her role as patient advocate first and foremost. This appeared to demonstrate the leadership characteristics and expectations of a senior nurse, in this case that of the BCN in her commitment to identify specific performance problems. Such encounters can be stressful and challenging. Nonetheless the participant was not deterred in her quest to strive for competent practice to improve performance and so enhance service delivery

## **4.5 ORGANISATIONAL ISSUES**

This study identified a number of categories that underlie the core theme, of organisational issues, as seen in chapter 3. These categories incorporate conflicts relating to individual differences, inconsistencies between core activities of caring for clients and restrictive working conditions.

### **4.5.1 Conflict and frustration**

For the purpose of this study the conflicts and frustration encompassed aspects associated with organisation of the clinic and coordination and delegation of activities of team members. Only one BCN highlighted that she felt it was her responsibility to make decisions about whether nursing care was needed and believed this to be integral to the autonomous role of the BCN that was not driven by other team members' decisions.

....I want to be able to make a decision as to whether I'm needed or not and it's **me** (*participant emphasis*) that wants to make that decision, not somebody else. BCN4

It was apparent that she felt it appropriate to argue for the right to exercise professional autonomy, independence and control over her practice. In her account, the emphasis was on the importance of autonomy, but there was also an intimation of, at times a feeling of powerlessness and resentment that her role and skills were not being fully recognised. This may be interpreted as the BCN's ability to plan and coordinate delivery of care being hampered by their position within the hierarchy of the BSAC team. This was further emphasised by an apparent lack of communication that was also felt to contribute to the BCN's feeling of having their role undermined.

it wouldn't be a problem if you were given some sort of idea as to what's going on. I sometimes feel that I've no idea what's going on unless I keep going and saying "What's happening? What's happening with this lady? What's happening with that lady?" BCN4

This BCN seemingly experienced a sense of isolation despite attempts to be included and the lack of communication and negotiation appeared to disempower her decision base. It can be argued that poor communication may be related to power struggles and dissatisfaction within the team. This is in stark contrast to the previous discussion relating to team dynamics that suggested good team working. Similarly, good team working is based on "interpersonal niceties" and not team performance, or effectiveness. However, it is beyond the scope of this study to explore this particular phenomenon in any greater depth and further research is recommended.

#### **4.5.2 Team dynamics**

It is of note that within the context of team dynamics, there was very little reference to specific personalities and negative attitudes of individuals; this may also be attributable to the prolonged period of time working together and common understanding. Although effective team working was apparent for the majority of participants, there were areas where perceptions of lack of support and/or team



working were evident. It was noted by one participant that, from her own experience in practice, criticism of a colleague was somewhat difficult where performance and health outcomes were affected. However, the BCN did not negate her professional responsibilities in pursuit of necessity to fulfil her duty of care:

I think when you work in a small team it's quite difficult to criticise your colleagues. Whilst some of the team were aware of the problems they found it difficult to voice their concerns they didn't feel there was enough to make it an issue. But I disagreed with that. BCN2

Another participant expressed some concern where the skills and performance of the BCN were seemingly under rated:

.. I think that we can be under-valued in the clinic BCN4

Unfortunately, whilst acknowledging her thoughts and feelings, this individual did not give the reasoning behind her statement and was not explored further. Anecdotal evidence also supports this notion and with the lack of research relating to the role of the BCN in the BSAC, it seems reasonable to conclude that BCNs do not necessarily always function at an appropriate level in the BSAC. Nevertheless, in the main, there was evidence to support the presence of a cohesive team approach characterised by mutual respect and encouragement. In particular, one participant gave an account that clearly demonstrated the process of inter-professional working and back up available within the radiology team. The individual was seemingly in a senior radiology role with authority and potential influence and as such provided a supportive role to the radiology team:

Obviously because the radiographers and I work together the whole time, you pick up the grumbles. R1

It is noteworthy that the same individual identified the potential lack of support and understanding for those BCNs working within the BSAC:

...whereas I don't think the BCNs grumbled to me because I'm probably not around for the BCNs to grumble at me.

R1

It is my belief that deficiencies of such supportive processes can reinforce role uncertainty where different individuals have different expectations eventually leading to isolation, frustration, conflict and ultimately job dissatisfaction.

#### **4.5.3 Workload demand**

Being the only BCN in BSAC is disadvantageous at times and as identified by most of the BCNs. They shared their concern that some clients may not have had the opportunity to see the BCN whilst attending the BSAC due to workload commitment. This finding is also supported by Pineault (2007) who suggests that, with the high number of attendants to the BSAC it is unrealistic and unachievable expecting the nurse to meet with all the clients:

..in an ideal world we would be seeing everybody and, you know, it's not always practicable..

BCN4

Nevertheless, two of the BCNs acknowledged this perceived shortfall but provided little in the way of suggestions to manage this aspect of client care. It can be argued that these BCNs felt they had little or no influence in the provision or organisation of care and the assessment of client need.

A further consideration was identified from the perspective of the radiology team:

. ...Because generally there is one of you and especially we can have two biopsies or three going on at the same time. I think sometimes it can impact on the roles, but I suppose it all depends on the pressure of work and I also think it depends very much on the person who is at the clinic. R2

This participant's account acknowledged that at times, the clinic can be stretched during unexpected increased workload and this impacts on BCN performance. Nevertheless, it was recognised that in addition to demands on service delivery, personalities/attitudes can influence the BCN role in the BSAC. An implication of this

is that team dynamics and workload are important factors when considering team performance and, ultimately, the quality of care.

#### **4.5.4 Service limitations**

Further Organisational Issues were identified that were related to service limitations, specifically continuity of care, which again overlaps with the earlier discussion of Person Centred Care entwined with client support, information assessment and provision. However, it was felt necessary to include it as part of the discussions about issues that pose a dilemma for both clients and all the BCNs. It can be argued that a significant component of BCN activity involves co-ordination and liaison on a management level. Whilst this was raised as an issue for many of the BCNs there was little or no solution offered to reconcile or improve current practice. It is suggested that the present service provision lacks a coordinated problem solving team approach (see 5.2: Recommendation 5):

It would be ideal if you had the same BCN who knew you all the time, it would be nice if that were the case. You started off with somebody and you finished with that somebody.

CL1

All participants were keen to voice the importance in providing continuity of care, especially for those clients who proceed to surgical intervention beyond the remit of the BSAC. The above statement highlighted weaknesses, however the client recognised the benefit of establishing the client nurse relationship based on continuity and consequently person centred care. It is acknowledged that clinic organisation together with practicalities of the booking procedure may influence service delivery and continuity of care:

No, it doesn't always happen, there's not a lot you can do for that, because people always change their appointments, you know, you still have to get them through the process.

R1

These findings were beyond the remit of this study. They did, however, impact on care delivery and job satisfaction for the BCN within that particular BSAC. It is conceded that external influences, such as client preferences requesting appointment

changes, will unfortunately also impact on care delivery and result in fragmentary care for some clients.

#### 4.5.5 Perception of time

As previously stated in Chapter 3, all participants perceived time to be an important factor of client care. The BCN was observed to be in a prime position to invest time to meet the needs of those clients attending the BSAC:

.... it is quite important that there is someone semi-independent from the big bad Doctor who has just stuck a large needle into this woman to whisk her away who's got time, or is **perceived to have time** (*participant emphasis*), to sit with them and talk.

R1

R1 identified particular expectations of the BCN; there was an assumption that the BCN was available to meet the needs of the client in the BSAC. In this study, the above statement parallels the beliefs of several of the radiology team working in the BSAC. The implications of missed opportunities provoke a discussion around egalitarianism, the moral doctrine that people should be treated equally. It could be suggested that this was driven by client choice, lack of team collaboration, or due to resource limitations, in this instance namely that of time. There was an acceptance that time was limited during the doctor's consultation a finding suggested by Halkett & Arbon (2006). Nevertheless, in this study, post assessment discussion (an opportunity for clarification and closure) prior to leaving the BSAC offered by the BCN was seemingly judicious. As identified in Person Centred Care, this opportunity allowed for explanation, greater understanding and conclusion:

..... it is so quick in with the doctor. Well I feel I know that they are there, but I feel they are doing a job and are only allowed so much time, and not to take their time up. That's what I feel when you come out of there, then there is someone (BCN) to talk to.

CL1

Whilst time is a finite resource, it could be interpreted that the interplay between role definition, expectations and organisational issues impact on the perception of time and its best use to effect quality of care delivery. Considering the increasing numbers of clients attending the BSAC I would suggest that it is unrealistic to expect the BCN to provide time for all women.

## **4.6 CLINICAL PRACTICE AND NEW OPPORTUNITIES**

Within clinical practice, new opportunities have presented themselves as a result of role development. This has encouraged BCNs to incorporate some of the skills normally associated with the medical profession into their practice, whilst maintaining the core elements of nursing care. Medical and nursing practices are changing all the time due to external pressures driven by government initiatives and internal forces such as the increasing focus on career development, improved management and specialisation (Lloyd Jones 2004).

The introduction of specialist radiology practitioners in the BSAC and change in skill mix is now very apparent and, inevitably has had some impact on clinical practice within BSAC. With the increase in diversity of practice, inter and intra professional boundaries have become more blurred, highlighting the need for service review and re-evaluation of practices and developments. Overall, there seemed to be a positive attitude towards supporting development of the BCN role from the health professionals working in the BSAC. This is an important consideration in advancing practice, as one of the main factors identified that hinder or facilitate progress is relationships with other key personnel, as acknowledged by Lloyd Jones (2004).

### **4.6.1 Improvements and suggestions**

This category was closely related to how the BCN service might develop in the future. The category generated comments from all staff participants in BSAC. However, there was little or no comment from the client group. It can be argued that they believed the service performed satisfactorily and met their needs. It is recognised that this is only a small sample group and reflected only the opinions of clients with

normal benign results and not those with a breast cancer diagnosis who may have provided further insight. It can also be reasoned that there was a lack of expectation by clients when considering the BCN's role and the potential advantages this service might offer in terms of quality of care received. This was borne out in one of the categories linking the promotion of the BCN to the client. According to one of the radiology team, there is ambiguity felt about including contact details of the BCN in the invitation letter to the BSAC. This is presently a recommendation in the guidelines for nurses in breast cancer screening (NHSBSP 2008) and more recently in a patient satisfaction survey (West Midlands Cancer Intelligence 2007). However, this practice is not followed in BSAC involved in this study. This was as a result of previous experiences where referral enquiries appeared to relate to mammographic enquiries considered to be the responsibility of the radiographer. It can be debated this is a missed opportunity for BCN assessment and intervention and the provision of support for those clients with potential heightened anxiety.

Some participants suggested a combined approach with the radiographer and the BCN when meeting and discussing issues with the client at the pre-assessment stage. One of the participants, however, reflected on the possibility that this technique might be somewhat overwhelming and unsettling to the client and may not promote an atmosphere conducive to expression. An alternative suggestion put forward by a BCN was that meeting with a BCN at the time of attendance at BSAC could be inclusive to the routine assessment process and might be helpful in breaking down barriers and provide opportunities for communication and potentially promote client referral patterns post assessment visit. This idea was supported by some of the radiology team who appeared to recognise the possibility of lost opportunity for further involvement of the BCN. On balance there appeared to be a consensus of opinion within BSAC team that the BCN role is not sufficiently promoted to the client group attending the BSAC (see 5.2: Recommendation 6).

#### **4.6.2 Competencies and abilities**

A specialist nurse is educated and has experience in and develops competencies and skills in a specialist field. The integrity of the specialist is dependent on up to date

knowledge and research pertaining to their field of interest. All nurse specialists should perform within a framework that defines expert clinical practice: leadership, education, consultancy and research (Burnet et al 2004). However, individual practices will vary depending on the knowledge, skills, expertise and attitudes of the specialist nurse as identified in the following two statements:

I just think I would not be comfortable, I think I have got limits. BCN1

.... I personally never thought that one BCN necessarily needs to be exactly the same as the next person and everybody's got their own strengths and skills... BCN4

For the purpose of this study, the category of competencies was centred on the abilities most attributable to each of the professional groups within the BSAC. Arguably, from the perspective of some BCNs there was some discrepancy in the competency of their radiology colleagues in conveying information to the client specifically in areas relating to diagnosis/treatment:

....well I don't feel that the other person made any sort of judgement as to how much information the lady wanted BCN4

One BCN reflected her concern at the lack of a radiology colleague's proficiency in conveying information, believing the BCN is more suited to perform the activity. This has been discussed at length under the theme of Interactional Support. Interestingly, one of the radiology team shared this perception on the competencies of the different team members. Here, the participant believed the radiographer had the knowledge and skill to discuss issues relating to good news (that which focuses on non breast cancer breast conditions):

Radiographers, (the non-advanced practitioner radiographers) are probably just as good, at most levels, at giving good news and probably quite good at explaining all the other things. R1

However, a radiographer disputed this observation, recognising that BCNs have a wider range and depth of skill in comparison. On a personal level, the radiographer, whilst believing that she had a certain amount of aptitude, concedes her lack of experience and competency in discussing non breast cancer conditions:

..there is a huge percentage of women with benign disease  
(non breast cancer conditions) and that knowledge, we  
haven't got. RG3

BCN practice is based on specialist BCN training incorporating skills and competencies reflected in the clinical standards document (RCN 2007). This provides dimensions of breast care nursing designed to promote high quality performance and a definition for competent nursing practice. The document identifies minimum standards of educational development and the need to evidence attainment of the required skills and competencies. Professional responsibility was discussed under the theme of defining the role, where it was suggested that integrated working may be the way forward. For this to work, there would have to be clarification of core skills and competencies specific to the different professional groups and negotiation of boundaries to promote overall team performance. Analysis of the different perceptions of roles and boundaries seems to support this notion. (see 5.2: Recommendation 7).

#### **4.6.3 Role development**

Through the process of NHS reforms (Forrest 1987), professional and patient led demands, nursing practice has become more diverse and as a result there have been changes in the range of skills, boundaries and practice for the BCN. As a result, there are various descriptions used to explain these changes: role expansion, role extension and role development. For the purpose of this study, role development is defined as that which encompasses practices and the acquisition of additional skills, some of which are usually associated with practice of other health professionals, or those nurse-led, but not formally integrated into BSAC (Buchanan 2007).



The implications of changing needs of the client may provide new opportunities for future role development of the BCN in BSAC. However, this will require negotiation and consultation with other BSAC health care professionals before changes in practice can be embarked upon. Suggestions relating to role development were varied, some controversial, and others were somewhat thought provoking.

History taking suggested by one BCN was thought to add potential value to the assessment process and also assist in the initial treatment decision and avoid compromising future care for those likely to incur a diagnosis of breast cancer. The radiologist made various suggestions about how the BCN role could be developed, including performing breast examination; results giving and ultrasound scanning. However, within the confines of the BSAC involved in this study, it became apparent that as a result of the introduction of the four tier staffing initiative and further training and development of radiographers these spheres of practice were perceived mainly the remit of the radiology team.

One BCN felt confident to undertake the responsibility to deliver benign results to clients. A study undertaken by McDonald et al (1996) found that patients continued to be worried and more anxious following consultation of normal results from the doctor. Applying this evidence to the BCN role provides an argument that such a role has the potential for optimisation of client care. However, any role development needs to take into account priorities of care delivery and how it fits with existing practice and current workloads. It is imperative that the interests of the client, the BCN and other health care professionals are safeguarded when considering new activity.

There have been few studies that have evaluated the psychological impact for women attending BSAC. In particular, Sandin et al (2002) demonstrated that psychological effects, whilst not prolonged, were evident post BSAC attendance. This seems to support the argument that for those clients with heightened anxiety, or where breast knowledge is deemed to be an important aspect of their assessment but felt inappropriate at the time of attendance, the option of referral to a nurse led clinic (external to the BSAC) may provide additional benefits. This potentially radical

concept may not only benefit the client, but could be a cost effective exercise (see 5.2: Recommendation 8). Ultimately, development of roles and skills must be accompanied by appropriate education training and practice based experience. However, role developments and new opportunities also give rise to the potential beneficial effect of increasing motivation, job satisfaction and encouraging staff retention.

#### **4.6.4 Training and education**

This category derived from participants' discussions relating to BCN training and education requirements. One BCN placed particular emphasis on psychological support and the need for further education in psychosocial assessment to help understand and identify needs of clients attending the BSAC. It was of interest to note that one of the BCNs, whilst acknowledging that she held a counselling qualification, still experienced a lack of confidence and competence in this area of her practice:

...I have done counselling, the certificate in counselling  
and but perhaps I'm not as good as I should be. BCN1

It is important to acknowledge limitations and learning needs and she clearly demonstrated a very professional approach to her perceived lack of competence and need for further development of her counselling practice. She suggested that a more structured psychosocial assessment might be incorporated, not only to improve practice, but also client outcomes. The impetus for improvement was acknowledged as personal to this BCN. From her perspective there was an identified need for further education and training to enable her to perform more effectively and be able to utilise specific skills that acknowledge the clients own unique feelings and concerns. The BCN felt that she may assist the client more effectively through the process of more structured enquiry, as the client journeyed through the BSAC. Another BCN acknowledged other areas of training and education within this category associated with the BCN's role of educating clients in breast awareness in BSAC. This was also highlighted by one of the radiology team as a potential benefit and substantiated further by a client as previously discussed under the theme of Interactional Support.

The central premise of education and experience are mutually important and inform other health care workers within differing areas of practice. A comment made by one of the radiographers indicated that education could be reciprocal within the team, thereby contributing to a wider knowledge base. Such a mutual arrangement has the potential for greater understanding, integration and resourcefulness. By implication this has the potential to improve overall performance, promote effective collaboration and, at the same time, enhance client outcomes. Both clinical experience and education are important facets in the make up of a BCN. Qualifications in terms of basic prerequisites and specialised courses are important for the role. Education alone is not considered to be sufficient, the addition of clinical experience in combination with education together create the expert BCN. As an autonomous specialist, accountability and responsibility are integral to practice where confidence in decision-making is a necessity of the role.

#### **4.7 Summary**

The categories collectively identifying the theme Person Centred Care recognised the client as an individual and focussed on a rich understanding of the human being, their circumstances and their needs. Person Centred Care is often linked with nursing and is an important feature that defines nursing, characterised by their theoretical and practical framework. This was illustrated throughout the Chapter highlighting elements of care attributable to the minimisation of anxiety. The promotion of a supportive environment was identified principally with the BCN in BSAC.

Communication and interpersonal skills were identified as essential to the BCN role in the BSAC. An attempt was made to recognise differences in health care professionals approach, the potential advantages of BCN involvement and the role played within the confines of BSAC. This was further linked to the complexities of communicating information relating to breast awareness. Whilst there was recognition of the need and importance of such activity from the clients and the BCNs, there lacked a coordinated team approach and evidence in the application to implement this within BSAC.

Peer support was also promoted by some of the participants as an area of potential benefit, facilitating new learning and improved development. The concept of sharing events and incidents was seemingly to provide enlightenment and rewards for both parties working in a potentially highly stressed clinic.

Defining the role of the BCN in BSAC created much discussion and debate. The majority of BCNs were unanimous in acknowledging such uncertainty. It is apparent that the main emphasis of the BCN role is to support those clients with a potential breast cancer diagnosis. However, it was proposed that with the BCN's comprehensive breast knowledge, this supportive role has potential benefits for those women with benign or normal breast results. It was apparent there was little consensus in defining the BCN role in BSAC and was reflected in the lack of appreciation of skills and competencies to perform tasks associated with this element of care.

Organisational Issues reflected the challenges and conflicts driven essentially by resource limitations and work environments. True collaboration requires effective communication and at times there was evidence indicating a less than co-ordinated and coherent approach to team working. Lapses in communication tended to isolate the BCN, inhibiting the right to exercise her professional autonomy, independence and control over her area of practice.

Clinical Practice and New Opportunities concentrated on the BCN acquiring new skills and developing new ways of working within the BSAC. The emphasis was placed on direct client care, combined with clinical procedures, client education and information provision. Role development was seemingly influenced by the individual BCN's perception of the scope of the role, level of experience and educational requirements. Nevertheless, there was evidence to support new opportunities for the BCN in BSAC, provided that they acquired the appropriate education and training, levels of competence and prepared to be accountable for their new practices.

The following chapter will present the conclusion, recommendations and an evaluation of the research project.

## **CHAPTER 5**

### **CONCLUSION AND RECOMMENDATIONS**

#### **5.1 Introduction**

The previous chapter considered the findings and discussed these with illustrative statements from the transcripts representing the identified 5 themes. In this final Chapter, I reflect upon the objective of this study. The intention; to explore the role of breast care nurses (BCN) and gain greater understanding of their function to inform on future practice. The key objective was aimed at capturing key stakeholder perspectives and gain greater understanding and appreciation of the role within the assessment setting, through in-depth semi structured interviews. This, I believe is relevant to health professionals and others concerned with care delivery in BSAC and has specific relevance for the BCN role and the NHSBSP.

Furthermore, a table of recommendations is presented to support additional improvement in promoting effectiveness of the BCN role in BSAC and optimal client care. In conclusion, I will evaluate the research project and consider the strengths and limitations of this study and the implications for future research and practice.

#### **5.2 Recommendations for practice**

The rational for the following recommendations were associated with identified common themes demonstrating lack of efficacy, reinforced from the findings of this study.

1. Acknowledge BCN advanced clinical skills and examine the potential function in BSAC.
2. Explore the use of a client self-assessment anxiety tool, to identify anxiety levels of clients attending BSAC with the intention of providing appropriate and timely BCN intervention identified by client need.

3. Explore methods to provide relevant information to support client care through the process of BSAC investigations to the medical consultation in the outpatient breast clinic.
4. Identify regular service review to encourage positive team dynamics and effective team working.
5. Explore/evaluate breast awareness education by the BCN in the BSAC.
6. Explore appropriate means to Profile the BCN role in BSAC.
7. Agree boundaries. Identify and share work tasks common to all BSAC team. Develop mutual respect and understanding for areas that are distinct and not open to share.
8. Investigate the effectiveness of BCN nurse led clinics associated with BSAC.

### **5.3 Evaluation of research Project**

This study has provided insight into the role of the BCN in BSAC and has explored the factors that contribute to a greater understanding of the value of BCN contribution to assist optimal client care during BSAC.

### **5.4 Study Strengths**

This study has provided evidence of the potential and actual advantages that the BCN offers in the provision of nursing contribution. Whilst it has not been possible to truly define the BCN role in the BSAC, this qualitative study has helped to construct a picture of the nature of BCN work in the BSAC, based on the views of clients and participants working in this setting. In addition, this study has created an opportunity to explore potential scope for BCN role development and an opportunity to enlighten BSAC team members of the seemingly apparent latent capabilities of BCNs.

## **5.5 Study limitations**

Reflection on the research process and findings identified a number of important theoretical and practical issues. Conducting insider research may be associated with potential limitations and possible effects for data collection and analysis; this is discussed further in this chapter. Issues of validity (such as bias), subjectivity and ethical issues, (including anonymity and possible coercion) were factors requiring awareness and careful management by myself.

Constraints of time, budget and personnel may have contributed to several limitations with potential impact on this study. First, biases in recruitment may have existed. Eligible clients were recruited initially by post with poor response. As a result, face-to-face contacts were subsequently used to recruit clients which may have influenced anticipated positive response. This study reported on the role of the BCN in one BSAC, hence may not be applicable to other settings. The variation in the radiology team roles descriptors apply with due consideration of the potential unique practices in this and other settings. The NHSBSP unit involved in this study was one of the initial pilot centres to introduce the new collaborative working initiative as described in Chapter 1. Whilst the initiative is being implemented in other centres, this may not presently be representative of all NHSBSP units in the UK. However, generalisability was not the primary intent of this qualitative study, nevertheless the findings from this study may have relevance for other BSAC and the development of the BCN role in these clinics.

Client interviews were limited to those with non-breast cancer diagnosis and therefore might have provided limited insight of the BCN role. It could be inferred that cancer patients might have responded differently and therein provided more comprehensive and informative data. However, it was felt inclusion of this group may have contributed to greater client distress and therefore were not recruited.

The concept of insider research, (a researcher who researches their own organisation) highlights specific issues for consideration; namely the impact on the BSAC team, demands on the researcher and the quality of the research. As the insider researcher,

some of these issues became apparent and it was evident from some of the participant's statements in Chapter 3 and 4, RG1, BCN3 and BCN4 struggled to divorce my role as researcher from that as a BCN. It was evident that a 'taken for granted perspective' was adopted at times during the data collection process. It is acknowledged that within the dynamics of an insider researcher and the participants there are potential positive and negative impacts to research. Notably, Smyth & Holian (1999) expounded the benefits of insider research focussing on the potential for development within the organisation and the opportunity to learn about ourselves and others to influence improvements in everyday practice. Working in the same clinical environment as the participants can be advantageous, because as the researcher, I had insider knowledge of practice (Smyth & Holian 1999). For example, one participant responded with 'you know what I mean, don't you', a comment which may have helped participants to confirm common understanding and assisted in the translation of meaning with greater understanding. A further incident highlighted a participant response addressing me as a BCN working in the BSAC and not as the researcher during an interview. The dynamics of the situation may have had potential negative effects and impacted on the participant's ability to be open and honest. It was imperative I remained aware to these potential situations and encourage integrity; this is demonstrated in appendix six. It was therefore important to maintain awareness that these effects might bias data collection and analysis, thereby impacting on credibility of the research.

## **5.6 Implications for future research and practice**

This study has not fully addressed issues around the effectiveness of the BCN and whether the existence of the BCN makes any difference to client outcomes. Therefore, possible beneficial effect on client outcomes in terms of women's health warrants further investigation.

Based on the findings of this study the researcher has been instrumental in informing action that has resulted in the implementation of some of the recommendations made. Recommendation 2 has been acted upon and a protocol devised to address issues relating to continuity of care for clients post BSAC. This protocol is currently in the early stages of being implemented and evaluated.



Recommendations 1 and 8 have resulted in setting up a working party to explore appropriate means of profiling the BCN role to those clients attending BSAC. In conjunction with this, the working party is to examine the use of a client self assessment anxiety tool to identify anxiety levels of those clients attending BSAC. The intention is to provide appropriate and opportune BCN intervention identified by client need. This is in the final stages of development and will be piloted in due course.

This study aimed to explore the role of the BCN and could be used as baseline information to inform the planning and evaluation of further research in this area. It is suggested that gaining greater understanding of BCN function will assist to inform on future practice within the BSAC. New understanding and awareness provides an opportunity for greater understanding and improved working relationships within the BSAC team. If given the resources and commitment to implement recommendations, this may contribute to enhance client care, promote greater team collaboration and job satisfaction.

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## APPENDIX 1

Search strategy 20<sup>th</sup> December 2005

No.	Database	Search term	Info added since	Results
1	CINAHL (R) -1982 to date	Nursing- role. DE.	Unrestricted	16856
2	CINAHL (R) -1982 to date	Advanced- practice- Nurses#.DE.	Unrestricted	13320
3	CINAHL ( R ) -1982 to date	Nurse-attitudes.DE,	Unrestricted	7978
4	CINAHL (R) -1982 to date	Breast-examination#.DE.	Unrestricted	963
5	CINAHL (R) -1982 to date	Mammography.W..DE.	Unrestricted	2523
6	CINAHL (R) -1982 to date	Breast-neoplasms#.DE.	Unrestricted	11654
7	CINAHL (R) -1982 to date	Breast-diseases#.DE.	Unrestricted	12155
8	CINAHL (R) -1982 to date	1 AND 2 AND LG=EN	Unrestricted	1988
9	CINAHL (R) -1982 to date	2 AND 3 AND LG=EN	Unrestricted	274
10	CINAHL (R) -1982 to date	8 OR 9	Unrestricted	2200
11	CINAHL (R) -1982 to date	(4 OR 5) AND LG=EN	Unrestricted	3105
12	CINAHL (R) -1982 to date	10 AND 11	Unrestricted	6
13	CINAHL (R) -1982 to date	(6 OR 7) AND LG=EN	Unrestricted	12083
14	CINAHL (R) -1982 to date	10 AND 13	Unrestricted	18
16	CINAHL (R) -1982 to date	12 OR 14	Unrestricted	18

Search strategy 20<sup>th</sup> December 2005

No.	Database	Search term	Info added since	Results
1	MEDLINE - 1996 to date	NURSE-CLINICIANS #. DE. AND NURSES-ROLE#.DE.	Unrestricted	784
2	MEDLINE - 1996 to date	BREAST- NEOPLASMS #.DE. AND ONCOLOGIC- NURSING#.DE.	Unrestricted	185
3	MEDLINE - 1996 to date	2 AND 13 AND LG = EN	Unrestricted	6

Search strategy 20<sup>th</sup> December 2005

No.	Database	Search term	Info added since	Results
1	EMBASE - 1996 to date	Breast-Cancer #.D E.	Unrestricted	69840
2	EMBASE – 1996 to date	nur\$3 NEAR role	Unrestricted	1108
3	EMBASE – 1996 to date	9 AND 10 AND LG = EN	Unrestricted	24



No	Database	Search term	Info added since	Results
1	CINAHL (R) -1982 to date	Breast ADJ Screening AND recall	unrestricted	20
2	CINAHL (R) -1982 to date	Mammography#. W.. DE. OR Breast Examination	unrestricted	2807
3	CINAHL (R) -1982 to date	REScreening#. W. .DE	unrestricted	18
4	CINAHL (R) -1982 to date	Patient-Attitudes# .DE. OR Patient-Compliance#. DE. OR Consume R-Attitudes#. DE.	unrestricted	13091
5	CINAHL (R) -1982 to date	Patient Education#. DE. OR Information-Needs#. DE. OR Support-Psychosocial#. DE. OR Health Knowledge#. DE. OR Consumer-Health-information#. DE. OR Information-Resources#. DE.	unrestricted	101091
6	CINAHL (R) -1982 to date	(1 OR 3) AND LG-EN	unrestricted	37
7	CINAHL (R) -1982 to date	( ( 2 AND ( 4 OR 5 ) ) NOT 6) AND LG= EN	unrestricted	654
8	CINAHL (R) -1982 to date	7	unrestricted	425
9	CINAHL (R) -1982 to date	(8) AND PT= Research	unrestricted	254

Search strategy 23<sup>rd</sup> February 2005

No	Database	Search term	Info added since	Results
3	CINAHL ( R ) -1982 to date	Nurse ADJ practitioner	unrestricted	21246
4	CINAHL ( R ) -1982 to date	Advanced-Nursing-Practice.DE.	unrestricted	3922
5	CINAHL ( R ) -1982 to date	Advanced –Practice-Nurses#.DE. OR Nurse-Practitioners#.DE.	unrestricted	12708
6	CINAHL ( R ) -1982 to date	Assessment ADJ clinic	unrestricted	151
7	CINAHL ( R ) -1982 to date	Nurse-Managed-Centers#.DE	unrestricted	1138
8	CINAHL ( R ) -1982 to date	Nursing-Role#.DE	unrestricted	15307
9	CINAHL ( R ) -1982 to date	(3 OR 4 OR 5 OR nurse ADJ Specialist) AND LG=EN	unrestricted	33819
10	CINAHL ( R ) -1982 to date	9 AND 8	unrestricted	2903
13	CINAHL ( R ) -1982 to date	(6 OR 7) AND 10	unrestricted	45
14	CINAHL ( R ) -1982 to date	(13) AND LG=EN AND FEMALES=YES	unrestricted	8
15	CINAHL ( R ) -1982 to date	13 NOT 14	unrestricted	37

Search strategy 29<sup>th</sup> January 2007

No	Database	Search term	Info added since	Results
2	CINAHL (R) -1982 to date	(Nursing-Role- AM.MJ. OR Nursing-Role-PF.MJ. OR Nursing-Role-ST.MJ. OR Nursing-Role- TD.MJ.)	Unrestricted	349
3	CINAHL (R) -1982 to date	2 AND LG=EN	Various	169
5	CINAHL (R) -1982 to date	CLINICAL-NURSE- SPECIALISTS#.DE. AND NURSING-ROLE#.DE	Unrestricted	932
6	CINAHL (R) -1982 to date	5 NOT 3 AND LG=EN	Various	361

## APPENDIX 2

### Semi structured questions

1. Why do you think there are Breast Care Nurses working in the Breast Screening Assessment clinic?

*Prompts : emotional support/ information/ assist in clinical procedures/ health education/ facilitator*

2. What do you think is the role of the Breast Care Nurse in the Breast Screening Assessment clinic?

*Prompts: As above*

3. Were there any problems that you experienced with the breast care nurse? **OR** are there any problems you experience with the breast care nurse?

*Prompts: resource implications lack of availability/ staff conflicts/communication issues/*

4. What effect do you think the breast care nurse has on the quality of the service being provided?

5. What do you think would help or assist the breast care nurse to provide a more effective service in the Breast screening Assessment clinic?

## APPENDIX 3

(On Coventry University headed paper)

### PARTICIPANT INVITATION SHEET (Clients)

Dear Madam,

I am a breast care nurse specialist currently studying for a Masters by Research course at Coventry University. As part of the degree, I am undertaking a research project titled: Perceptions of the role of the breast care nurse in Breast Assessment Clinic, with a view to inform future practice.

The purpose of this study is to develop an understanding of the breast care nurses role in the Breast Assessment Clinic, with a view to inform future practice. In particular, I am interested to hear your comments that may help serve to develop this role and comment upon what you believe is best practice for breast care nurses in this setting.

I want to know your experience of the Breast Assessment Clinic and how the service may alter and develop in the future.

**Please will you read the enclosed information sheet, which explains the study in detail.**

If, after reading the information sheet, you would like to take part in this study, please complete the tear off agreement slip below and return it in the pre-paid self addressed envelope before..... If you do not wish to take part simply do not complete the return slip

#### Contact for further information

If you have any questions or comments in connection with the study please feel free to contact:

Judith Clarke  
Tel 0247 602020 ext 8443

Please cut here  .....

#### Agreement slip

I (Name).....am willing to participate in the above study.

Contact telephone number.....

Email address.....

**Please now return the slip in the pre-paid self addressed envelope to:**

**Judith Clarke  
Breast Screening Unit  
Coventry and Warwickshire Hospital  
Stoney Stanton Road.  
Coventry  
CV1 4FH**

24/02/2006

Version 3

**(On Coventry University headed paper)**

**PARTICIPANT INVITATION SHEET (Health Care professional)**

Dear Sir/madam,

I am a breast care nurse specialist currently studying for a Masters by Research course at Coventry University. As part of the degree, I am undertaking a research project titled: Perceptions of the role of the breast care nurse in Breast Assessment Clinic, with a view to inform future practice.

The purpose of this study is to develop an understanding of the breast care nurses role in the Breast Assessment Clinic, with a view to inform future practice. In particular, I am interested in hearing your views on your experience at the clinic, your perceptions of the role of the breast care nurse, and how it may be changed.

I want to know your experience of the Breast Assessment Clinic and how the service may alter and develop in the future.

**Please will you read the enclosed information sheet, which explains the study in detail.**

If, after reading the information sheet, you would like to take part in this study, please complete the tear off agreement slip below and return it in the pre-paid self addressed envelope before..... If you do not wish to take part simply do not complete the return slip

**Contact for further information**

If you have any questions or comments in connection with the study please feel free to contact:

Judith Clarke

Tel 0247 602020 ext 8443

Please cut here  .....

**Agreement slip**

I (Name)..... am willing to participate in the above study.

Contact telephone number.....

Email address.....

**Please now return the slip in the pre-paid self addressed envelope to:**

**Judith Clarke**

**Breast Screening Unit**

**Coventry and Warwickshire Hospital**

**Stoney Stanton Road.**

**Coventry**

**CV1 4FH**

**(On Coventry University headed paper)**  
**PARTICIPANT INFORMATION SHEET**  
(Health Care professionals)

**Title:** Perceptions of the role of the breast care nurse in Breast Assessment Clinic, with a view to inform future practice.

**Introduction**

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following carefully and discuss it with others if you wish. Ask us if there is anything that is not clear, or if you would like more information. Take your time to decide whether or not you want to take part. Taking part in the study is entirely voluntary, I would like to emphasise that you may withdraw at any time without giving reason.

This research is being conducted as part of a Masters by Research, at Coventry University

**What is the purpose of the study?**

The purpose of this study is to gain an understanding of the breast care nurses role from the views of clients and colleagues and to use these views to inform future practice. The aim is to provide evidence that may help serve to develop this role and comment upon best practice for breast care nurses in this setting.

**Why I have I been chosen?**

We need the views of clients and colleagues in order to gain a comprehensive insight of the breast care nurses role in this setting.

A total of 18 individuals from Coventry and Warwickshire area will be asked to participate in the study. These will consist of 6 radiologists/ radiographers and 6 breast care nurses who work within the Breast Assessment Clinic. Further views will also be sought from a total of 6 clients who attended the Breast Assessment Clinic.

**Do I have to take part?**

If you would like to take part you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and do not have to give a reason. If you decide not to take part in the study, or choose to withdraw, you will continue to be treated in the normal professional way.

**What do I have to do?**

If you agree to participate in this research you will be interviewed by the researcher. You will be asked to participate in one interview only. The interview will last for between 45- 60 minutes and will be conducted at the Coventry Breast Screening Unit.

Your interview will be tape recorded and then transcribed for analysis. The tapes and transcriptions will be destroyed at the end of the study.

**Are there any benefits?**

There is no anticipated benefit to you; however, if you decide to take part in this research, you the opportunity to influence the role of the breast care nurse in the Breast Assessment Clinic.

**Will my taking part in this study be kept confidential?**

All comments that are collected from you during the course of the research study will be treated as strictly confidential. In addition, your participation in the study will also be kept strictly confidential. You will not be identifiable in any reports or publications arising from this study.

**What will happen to the results of the research study?**

The results of the study will form part of a Masters by Research thesis and will be published and presented at nursing /medical conferences. It is important to emphasise, again, that it will not be possible to identify you individually in any presentation or publication. If you wish to obtain a summary of the findings, please contact Judith Clarke.

**Who is organising and funding the research?**

Coventry University in collaboration with University Hospitals Coventry and Warwickshire NHS Trust is organising and funding the study.

**Who has reviewed the study?**

Ethical Review Committee at Coventry University and Coventry Research Ethics Committee.

**Contact for further information**

If you have any questions, comments or problems in connection with the investigation please feel free to contact: Judith Clarke Tel 0247 602020 ext 8443

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study please contact:

Sharon Wyman

Complaints Manager

UHCW NHS Trust

Clifford Bridge road

Coventry CV2 2D

Tel 024 7653 5272

**Thank you for reading this information sheet**

24/12/2006

Version 3



**(On Coventry University headed paper)**  
**PARTICIPANT INFORMATION SHEET**  
(Clients)

**Title:** Perceptions of the role of the breast care nurse in Breast Assessment Clinic, with a view to inform future practice.

**Introduction**

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following carefully and discuss it with others if you wish. Ask us if there is anything that is not clear, or if you would like more information. Take your time to decide whether or not you want to take part.

This research is being conducted as part of a Masters by Research, at Coventry University

**What is the purpose of the study?**

The purpose of this study is to gain an understanding of the breast care nurses role from the views of clients attending the Breast Assessment Clinic and of colleagues, and to use these views to inform future practice. The aim is to provide evidence to support development of this role and to comment upon best practice for breast care nurses in this setting.

**Why I have I been chosen?**

You have been chosen, because you have recently attended the Breast Assessment Clinic. A total of 6 clients are being invited to participate in this study. Six radiologists/ radiographers and 6 breast care nurses who work within the Breast Assessment Clinic are also being invited to give their views of the Breast Assessment Clinic.

**Do I have to take part?**

**It is up to you to decide whether or not to take part. If you do decide** to take part you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time or a decision not to take part will not affect the standard of care you receive.

**What will happen to me if I take part?**

If you agree to participate in this research you will be asked to participate in one interview only. You will be interviewed by the researcher. The interview will last for, between 45- 60 minutes and will be conducted at the Coventry Breast screening Unit.

With your permission your interview will be tape recorded and then transcribed for analysis. The tapes and transcriptions will be destroyed at the end of the study.

**What are the possible disadvantages and risks of taking part?**

No disadvantages or risks are anticipated should you decide to participate in this research.

**What are the possible benefits of taking part?**

There is no direct benefit to you; however, if you decide to take part in this research, you will have the opportunity to influence the role of the breast care nurse in the Breast Assessment Clinic.

**Will my taking part in this study be kept confidential?**

All comments that are collected from you during the course of the research study will be treated as strictly confidential. In addition, your participation in the study will also be kept strictly confidential. You will not be identifiable in any reports, or publications arising from this study.

**What will happen to the results of the research study?**

The results of the study will form part of a Masters by Research thesis and will be published and presented at nursing /medical conferences. It will not be possible to identify you individually in any presentation or publication. If you wish to obtain a summary of the findings, please contact Judith Clarke.

**Who is organising and funding the research?**

Coventry University in collaboration with University Hospitals Coventry and Warwickshire NHS Trust is organising and funding the study.

**Who has reviewed the study?**

Ethical Review committee at Coventry University and Coventry Local Research Ethics Committee.

**Contact for further information**

If you have any questions, comments or problems in connection with the investigation please feel free to contact: Judith Clarke Tel 0247 602020 ext 8443

**What if anything goes wrong?**

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study please contact:

Sharon Wyman  
Complaints Manager  
UHCW NHS Trust  
Clifford Bridge road  
Coventry CV2 2DX  
Tel 024 7653 5272

**Thank you for reading this information sheet**

24/12/2006

Version 3

## APPENDIX 4

**Research study:** Perceptions of the role of the breast care nurse in Breast Assessment Clinic, with a view to inform future practice.

### CONSENT FORM

**Please initial box**

I confirm that I have read and understand the information sheet: version number .... dated.....  
for the above research study and have had the opportunity to ask questions.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my medical care or legal rights being affected.

☐

I understand that responsible individuals may look at sections of my interview transcripts, where it is deemed to be appropriate and relevant to the research. I give permission for these individuals to have access to these documents.

☐

I agree to take part in the above research study

☐

I understand that the interviews will be taped and then transcribed. The tapes and the transcriptions will be destroyed on completion of the study.

☐

Please sign both the investigator's copy and participant's copy of the consent form.

**Name of Participant**

**Date**

**Signature**

**Name of investigator**

**Date**

**Signature**

Version 3

15/01/2006

## APPENDIX 5A

### INITIAL SEMISTRUCTURED QUESTIONS

1. Why do you think there are Breast Care Nurses working in the Breast Screening Assessment clinic?

*Prompts: emotional support/ information/ assist in clinical procedures/ health education/ facilitator*

2. What do you think is the role of the Breast Care Nurse in the Breast Screening Assessment clinic?

*Prompts: As above*

3. Were there any problems that you experienced with the breast care nurse? **OR** are there any problems you experience with the breast care nurse?

*Prompts: resource implications lack of availability/ staff conflicts/communication issues/*

4. What effect do you think the breast care nurse has on the quality of the service being provided?

5. What do you think would help or assist the breast care nurse to provide a more effective service in the BSAC?

6. How do you think that the BCN service might develop in the future?

*Prompts: Formalised health education sessions/ Post assessment interventions/ Use of modified psychological assessment tool*

## **APPENDIX 5 B**

### **Pilot study**

#### **Amended questions post pilot study analysis**

Q4 what do you think are the factors that contribute to the quality of care delivered in the BSAC you receive?

Does the BCN contribute to that/those?

This is my list

- ☐ Efficient and timely delivery of service
- ☐ Patient education (health promotion/ breast awareness
- ☐ Good communication, skilled sensitive
- ☐ Quality information written/ verbal
- ☐ Contact details for self referral following BSAC

Would you include these as part of the BCN role?

Q5 How do you think the BCN service might develop in the future?

*Prompts: Formalised health education sessions/ Post assessment interventions/ Use of modified psychological assessment tool*

## APPENDIX 6:

### ILLUSTRATION OF ANALYTICAL PROCESS

#### TRANSCRIPTION RG1

JC Hello RG1, thank you for accepting the invitation to participate in my study. You read the participant sheet?

RG1 Yes

JC So you know the purpose of the study is to try and get an understanding of the breast care nurses (BCN) role in the Breast Assessment clinic (BASC). And I'm particularly interested to hear your comments, so I would really encourage you to be very honest, and open, good bad or indifferent, because if you aren't we will lose sight of the real objectives of the interview.

RG1 Of course.

JC Just to say, anything you say is purely confidential, alright.

RG1 It won't be taken in evidence (laughter)

JC It won't be taken in evidence (laughter) and I guess the interview will be approximately 45 minutes something like that. Err, I might just jot a few notes down as we go along if that doesn't bother you?

RG1 No that's fine.

JC Ok. Now since the advent of Breast screening, oh some years ago now and we both have been along that line haven't we?

RG1 We have.

JC The BCN has been apart of the BASC, just to get a feel of why you think the BCN was working in the BASC, why do you think she was there?

RG1 Well I think she is there to pick up the ladies, to have a link person for particularly the ladies who move on from assessment to have treatment, so they have one person that they will see on more occasions than just the radiographers, or even the radiologists here, so its like a link person. It's also another pair of hands in the clinic, with somebody who has communication skills and understands the patient and can help us to cope with them, as well for various procedures we do, so its two roles.

JC so when you say another pair of hands, how would you envisage the BCN when you say an extra pair of hands?

Link person  
Ass → Tx  
Ongoing contact  
Extra help  
Supporter  
Dual role

Continuity of care

(communication)  
Psychological support

Assists team  
in procedures  
Organiser  
Experienced person

Role  
Clarification  
and  
Communication

RG1 Well helping some of the procedures and assisting the doctors and some of the operators for doing some of the biopsies, so its someone who will look at the lady, help you to sort out things you need to do with them and also communicate with them at the same time, so you are another very experienced person in the clinic.

JC You talk about the communication side of things, what do you think BCNs offer, when you say about communication?

RG I think you offer a lot of information, you offer a link person for that patient as they move through and who understands what they have gone through with the assessment process and various tests that they have had done and you are another voice for the professionals for that lady aren't you, because you have been with them from assessment right through to treatment, you seen what has happened in the BASC and you are there for them to speak up for them in the MDMs and at the clinic for them when they go to see the Doctors. Because, I think our set up here having the outpatient clinic separate to assessment makes things a little bit difficult sometimes for following through, so it makes it a bit more seamless doesn't it?

JC So, you are saying basically when a patient, when a woman comes through to the BASC she is seen here to promote the continuity of care..... (Interruption with RG1 comment) RG1 Yes absolutely.

JC (Completes sentence) Should that person be diagnosed with a breast cancer.

RG Yes.

JC What about for those individuals that have a benign condition?

RG1 Well I don't quite understand how you can follow them through and give them the information at the BASC and you can fill them in a little bit more on how they deal with cysts or pain or what ever it is that they have got that is benign and we going to send them away home aren't we? Whether you can be a link person for them to phone you up afterwards? Cos I don't think you give them information very often for them to get back in touch with you as a breast care nurse. Where as they can get back in touch with us, but for the benign ones it does just finish there, but you a another person for them to give information to them.

JC So do you say you promote the BCN role for those patients that are given the diagnosis of benign disease and are reassured and discharged from the BASC?

RG1 Erm..I think you are more there for the role for those that have got somethir

Continuity of care

Advocacy

Organisational issues for

Clients with potential breast cancer diagnosis

BCN role ambiguity

Solution searching

Role responsibilities (Expectations)

Role clarification

Adaptability & flexibility Team Dynamics

Workload Demands

more real that has got to have treatment for it. But for the benign ones if you are there then you have got the information for them, but I think that is shared with the radiographers, the more experienced radiographers, the advanced practitioners who can do that role as well. But sometimes we are busy doing other things and if you are around and you are not dealing with patients that need to for treatment then you can be there to talk to the more benign problems that need to be sorted.

JC So would you say the BCNs have those skills to convey the information with regard to benign disease, like cysts, breast pain, those kinds of things, do you think we have those skills?

Competency  
Issues  
BCN dealing with benign conditions

Experience  
Education  
Ability

RG1 Yes I do because you are seeing them all the time in the clinic when you are in outpatients as well, hearing the course that you are doing a lot of you then yes I think you have that information.

Training  
Education

JC But were you saying that the main thrust of the BCN in the assessment clinic is really to identify those high risk patients that would potentially have a diagnosis of breast cancer.

(RG1 perception)  
Primary/secondary  
Role clarification

RG1 Yes I do, I think that is your primary role and the other role is secondary to but you have got the information to give ladies haven't you?

Role clarification  
Identified priorities  
(Expectations)

JC ok

RG1 But your primary role is to follow them through.

JC ok thank you.... (Pause) I think we have just clarified what you think; why you think they were there. The next question is what you think is the role of the Breast care nurse in the BASC, what do you envisage is the role and would you say it is purely about. No let me hand that over to you instead of me saying what exactly it is.

What do you think is the role of the breast care nurse?

(RG1 perception)  
Identify women  
info/support  
familiarity  
continuity

RG1 I think your role is to pick up the ladies and to give them the information they need to help them on the way for treatment basically so that you meet them, so they have a face they recognise someone they have already had a rapport with and you are going to follow them through

Role clarification  
(Expectations)

Continuity of care  
(Relationship building)

JC Mmm.

RG1 Whether it is you going through to Coventry or these ladies if they are going to another hospital they have to meet another team, well they will meet another team where ever they go won't they, but if they see you there or one of your team then that

Link  
Information  
Advocate (Pt)

Continuity of Care

Patient representative

Advocacy

Patient advocate



is their link isn't it? So I think primarily you are giving the ladies the information , you know what they are like, you are going to stand up for them at the MDMs as well cos you have met them in the clinic. The MDMs are discussed before they go back to outpatients so you are their representative as well as the radiographer, but if you have been talking to them then (sentence fades)

JC So we can be a voice for the patient in some respect if we have identified issues of concern in the assessment clinic and if they are going on to a potential diagnosis of breast cancer

Rg1 Yes.. yes yes..... Yes.

JC There is that familiarity or that relationship building that is going on. Is that what you are saying?

RG1 Yes, ok.. right... ok.

JC Have you, or do you foresee problems that you may have experienced with a BCN?

RG1 Err...

JC It maybe a difficult question to answer maybe, but I would like you to be quite and open honest if you feel there are any difficulties that you have experienced, or you see potential difficulties with BCN's role in the BASC?

(RG1 perception)

Difficulty

Duplication

RG1 The only difficulty I think is the start of the clinic, when you want to see tl| Frustration conflict ladies first and I think it gets duplicated.

JC Oh, ..Could you expand on that?

Seeks knowledge

Show films

Inform

Role reflection

Radiographer

Show films

Explanation process

Repetition

More knowledge

Duplication

RG1 Yes definitely, I think that the BCN very often has to come to the radiographer just to say this lady is going to see me. What has she come back for? We have to put the films up, find out why and then tell you and you are going to see the lady and tell them. Well personally when I take the lady in the room and I use to do it even before I was an advanced practitioner and knew a bit more about it even as an assessment radiographer I would show them the films. I would show them why they had been sent back and go through that with them in the room and then go on to explain what I was going to do next and explain what the whole process was going to be. But I just feel you met them, we are meeting them and that is a new face very quickly and we are telling the virtually the same thing and I think that perhaps the radiographer knows a little bit more because they have got the films there and they can explain

Conflict repetition



Team Dynamics

Role responsibilities

Role Responsibilities (Conflict)

them, so I just feel that that bit is always duplicated.

JC So you think the BCN actually comes in to this room prior to the assessment starting on that patient and talks to them about their radiography findings.

RG1 Yes, some of them do.

JC Right, ok aha ok.

RG1 I just feel that is duplicated. I think your role is somewhere a bit further along the line.

JC Can you expand upon that a little bit?

RG1 Well I think because if the ladies turn out to be nothing then they have seen the radiographer who goes so far and then you're coming in to take over to do the last bit if it is needed, otherwise that is just where it ends with the radiographer and the medic to dismiss them and I just think we delay the clinics sometimes a little bit, perhaps.

JC Ok, thank you for that. Is there anything else? Oh can I just go back one step?

RG1 Yes

JC Do you feel that we (BCN) impinge on the boundaries of the radiographer?

RG1 Yes I do, but I think the boundaries are a bit blurred, you have to merge from one to the other.

JC Yes?

RG1 But I just feel it starts with the radiographer because of the images and that's why we have called them back because of the images and that's why we should take them on to the next bit. Even perhaps if the BCN comes in to the room and just meets the patient with the radiographer while that is going on, that might be a way to merge the two a little bit more carefully.

JC How do you think that would work? How do you envisage that to happen?

RG1 Erm... I ..I well I don't know really, (laughter) its just off the top of my head .I just think it depends on personalities as well, but I think perhaps if it is a more worrying thing you could perhaps come and introduce yourself, but that would happen later on anyway, but that maybe a way round speeding it up a little bit , by letting the radiographer do her role.

JC Ok, that's very interesting. Have you experienced that as a problem with BCNs?

Can you think of an example that has happened?

RG1 Yes...well not particularly an example but sometimes I think we sit and wait

and we could get on with it and then I think we tell them virtually the same thing. The only time it is useful is when a lady has told you a problem and then you come and tell us and we are aware then on how to deal with the lady instead of going in and finding out ourselves. Sometimes we have had a bit of a warning if the lady is very anxious, stressed out or she has had something else happen and this has just come on top of it. That is always very helpful.

JC How does that help you then, when you say that we have picked up on an issue?

Communication  
Supportive  
role for  
base team

RG1 Well it helps you to know how to talk to the lady and be aware that she is going to be a little bit more anxious, perhaps doesn't like the pain of the mammogram, or she has had a bereavement and this is just going to make her life even worse for her so that we would just tread more carefully.

JC So we kind of set the scene for you?

Enlightenment  
Acknowledgement

RG1 Yes you set the scene yea that is the advantage of you seeing them first.

JC Ok . You picked up on the boundaries being blurred and there are issues around that for you. Do you have any issues around maybe some BCNs not turning up or lack of resources staffing issues?

RG1 Err yes sometimes nurses don't come from other hospitals and you have to erm and you have to make the communication back to the hospital and adds a bit of work on at the end and then the ladies go and see somebody completely different and obviously the radiographer is not going to go to the other hospital, so that does make things a little harder for the patient.

Conflict/frustration  
Workload  
demands  
Continuity  
of care

JC Ok Ok Any other issues that you think can pick up in terms of other problems or other things you have experienced yourself?

Rg1 I don't think I have picked up many problems really, no. I think it is a help having you in the clinic.

JC You do?

RG1 Yes definitely I don't think we could function without a BCN because you have got special skills and you are there to be part of the team, its a team and you have got a slightly different role to us and we have got to be aware that the roles are going to merge between us the doctors the radiographers and the BCNs.

Enlight/acknow  
Team  
Dynamics

JC Ok, I'm just thinking you say that we wouldn't be able to function without the BCN, however I'm just having some difficulty in understanding where you believe

Role (RG)  
Clarification  
(Expectations)

we fit in and where radiographers fit in?

RG1 Well the radiographers fit in with the imaging and the diagnostic process and with performing the tests, whether it's the mammograms, or the biopsies, or assisting with ultrasound. I think your role fits in more with the dealing with the talking to the patient, the communication side, giving them information and leading them on to the next step, if there is a next step involved. So its more for those that are going for treatment.

Role  
Clarification  
(BCN)  
(Expectations)

JC I'm thinking that the majority of women that come to the BACS are going to have a reassurance and discharge. I'm thinking that maybe if the BCN is going to be working with those high risk potential breast cancer diagnosis. We are not going to get many of those in the clinic are we?

Low numbers  
of high risk  
breast cancer  
patients

RG1 Well you will get 2 or 3 in a clinic don't you?

JC Mmm Yes I guess 2 or 3 maybe?

RG1 Yes and the other thing is if you are busy with those, talking to those ladies trying to sort them out after we have done the procedures and you are talking to them giving them information. We have got to take on other things like looking after the other ladies that are there waiting and sometimes we are talking to those that have had their biopsies and sorting them out because you are already dealing with one lady.

Busy  
talking  
Take on other  
duties  
Sort them out

Team  
Dynamics  
Workload  
Demands

JC Is that a frustration if we are with somebody else?

RG1 Err no I don't think it's a frustration, its .. I think that's where our roles overlap again isn't it? We've all got to deal with the ladies and their ones that have need to be sorted out and not kept waiting around too long. If we can do it we might as well get on and do it. That is where our roles overlap again.

Roles overlap  
Needs met  
Minimise waiting  
Manage service

Team  
Dynamics  
? Role  
ambiguity  
Client need

JC That's interesting isn't it? Thank you for your honesty, I appreciate that.

JC What effect do you think the BCN has on the quality of the service being provided?

RG1 (Quizzical Laughter)

JC I'm thinking of things like health education, I mean we haven't touched on anything like erm health promotion or anything like that. I hope I'm not putting words into your mouth, but I was wondering whether you foresee the BCN working in the BASC having any input with women about health promotion?

Reason	RG1 Well I think the ladies are here for one purpose only aren't they and that is to	Perception of client need (Expectation)
Deal with problem	deal with what ever the problem is that has brought them to the clinic.	
Information delivery	JC Right (ok)	
Health education & problem	RG1 The information we give out to them is often is health education isn't it and what ever the problem is for them....I'm not sure....(fades).	
	JC For example if they came with erm a lump and you found it and you found it to be cyst?	
Types of information Management verbal/written	Rg1 Yes we have information on cyst management haven't we on what they need to do in the future and you've got that information to give them out of your head as well as leaflets and we have got that as well some of us.	(Communication) Resourcing & utilisation of client information
	JC Mmm (Prompt)	
Education roles within the team	RG1 I think you are there to teach us things as well but we will do the same, like the other way round because of the various course we have been on.	(Communication) Training education
	JC Do you think that that has had an impact on the way the BCN's role is now? Because, maybe before advanced practitioners came along, people like yourself erm and people like the radiographer consultant it wasn't quite the same was it?	
Skill mix	RG1 No	
	JC So things have changed haven't they?	
Merging roles	RG1 And they are merging even more probably...yes	Role ambiguity
	JC Yes	Team Dynamics
Doctors role Health Promotion	RG1 And you've got to remember the doctor in all this and the information they have got to give and the health promotion aspects that they have got as well.	
	JC So it sounds to me that what you are saying is that there is some sort of confusion over roles	
Fusion of roles	RG1 I wouldn't say it was confusion it is a fusion of roles isn't it...(laughter) rather than confusion, I hope we are not confused with what we do (laughter) its more a merging isn't it and we have all got our little specialities and our little bits of in depth	Team Dynamics
Own specialities	of information and its putting them altogether for the lady isn't it and who is	Skill mix
Skill mix	available and who has got the information that that lady needs. Its not only just the information but its being able to tell the lady where to find things out for herself as well isn't it.	Communication Information needs
Staff availability	JC Like for example?	
Resource information		
Information source		
Future contact		
Breast awareness info Radiographer Self examine		

RG What to look for on the internet and what to ignore and if she has problems in the future how to get in touch with us, or back at her GP.. things like that.

Communication

JC What if a patient wanted information on breast awareness?

RG1 Well we give that out anyway don't we and we discuss it with them on mobiles and the radiographers should be very aware of breast awareness

(Expectations)  
Competency issues

JC And how to self examine?

RG1 Yes

JC Do radiographers do that as well?

Adv Practitioner  
ability

Rg1 No only the advanced practitioners will do it, but we give leaflets out about self examination (laughter) ....fades

Role clarification  
Competency issues

Teaching BA

JC I was thinking teaching women about self assessment, or awareness?

Rg1 Yes

Breast  
Awareness

JC You know the 5 point code?

Ambiguity

Rg1 Yes

Competency

JC I was thinking of that

RG1 Do you do that?

BCN availability

JC Yes

Confusion

JC Do you do that?

RG1 No (laughter)

RG 1 I do cos I can clinically examine a patient anyway as an advanced practitioner and I can tell a lady how to do it.

JC Right

Skill limitation  
radiographer

RG1 But no the radiographers don't.

JC Ok, so in areas in the BASC then, are you aware that BCNs can give that sort of information?

Role  
ambiguity

Lack of  
awareness of  
BCN role

RG1 No I didn't know that it went on.

Competency

JC Ok that's interesting so you don't know that BCN's have skills to show women how to do the 5 point code breast awareness.

Enlight/ackn

RG1 I assume that you can do that but you must be doing it over in the clinic, but I have never heard a BCN do it or give it to a lady.

JC Right ahh.. that's interesting.

R&D from clinic  
Lack of  
knowledge re  
BCN role & BA

RG1 I presume that's for the benigns really isn't it? The ladies are then going to walk

Role ambiguity

out of the clinic and we are finished with them. So I have never heard a BCN go over that with them before they have gone.

JC Would you ever ask a BCN to do that?

RG1 Now I would yes, cos you've just told me (laughter). So I can't say realised that before hand.

Acknowledgement  
Enlightenment  
Role ambiguity

JC So what we are picking up here then actually is that you probably actually don't exactly know the skills we have?

RG1 Yes yes

JC That's very enlightening, thank you for that.

RG1 I'm sure I don't.

JC I appreciate you're honesty again, because I think sometimes there is a lack of clarity about each others roles?

RG1 Yes definitely.

JC Yes and I think I have probably picked up some of things you have just said that I was not quite aware of as well.....ok so maybe there is some clarity that is required ?

Role  
ambiguity

RG Yes definitely

JC That's excellent I appreciate that too, grand.

JC In terms of, and this is the last question, in terms of looking at how BCN's roles can be more effectively utilised within the BASC, are there any areas that you think that BCNs possibly could be utilised more, or you feel are under utilised, or could provide a more effective service whilst the BASC is going on?

RG1 Mmm gosh that's a very broad question (laughter).

JC I wonder if I can make it easier for you?

RG1 Are there any more roles you can take on in the clinic?

JC Mmm.

RG1 Well its knowing what you're skills are isn't it, I've just realised, perhaps there are things that we haven't used you for.

Enlightenment

JC Mmm

RG1 On the more benign side.

JC Aah ah yes.

RG1 Perhaps we should be giving ladies a contact for you if they have got any queries about what has happened, but they usually contact us don't they, they will

Solution  
searching

Skills not used

Benign

Contact details

Clarification

Inclusion

Involvement

Role  
performance

What you are  
here for

Role  
clarification

Role  
ambiguity

phone back to us but you could be included on the information we give back to them so they can come back to us. Erm you get involved with our procedures quite a bit, I don't feel there is anything lacking there. Erm no I feel that the role you perform is probably what you are there to do. There is just this bit of a conflict sometimes or overlap of our roles isn't there, I can't think there is anything else.

JC I'm just thinking are there any developmental areas that you could think the BCNs could undertake in the BASC?

RG1 Erm perhaps clinical examinations might be one of them as a general thing especially as you have been talking about erm ladies wanting to be shown how examine themselves. But to do a clinical examination might be useful.

Solution  
searching

Role  
development

JC Mm

RG1 But the doctors do that as well I know and that's part of their role isn't it?

Role  
ambiguity

JC Yes but like you say about this fusion of roles, I think we are picking up the fact that there are some ambiguities about each others roles.

RG1 Yes

JC, would I be right in saying that?

RG1 Yes I think so, but we have just got to be aware of our own specialities haven't we and what we bring to the clinic with our knowledge and just try to combine it.

Team  
Dynamics

JC Would you ever see a BCN doing a communication course and a breast assessment, you could envisage that?

RG1 Yes definitely.

JC would you see them doing any other things in the BASC?

RG1 I can see you seeing some patients and examining them alongside perhaps the practitioners and doing that as a joint role as part of the team, because it goes very much alongside doing ultrasound anyway and everything happens around the ultrasound. That part of triple assessment. I can't see you doing it in isolation because that's not what assessment clinics are for, but I can see you taking on a more practical role, not just talking and imparting information but more of a practical role alongside the team.

Solution  
searching

Role  
development

JC Yes

RG1 Perhaps to examine patients.

JC You say not in isolation. What does that mean?

Role  
development

BCN role doing  
breast  
examination

Joint role

using  
ultrasound

Practical role

Information part  
of team

B.E as part of  
triple  
assessment



RG1 Not taking them off in to another room to do it on your own, but doing it as part of the triple assessment with perhaps the ultrasound, that seems to be the centre of what every thing happens around. Once the mammogram is done the lady is seen by the medic in the ultrasound room, probably with the radiographer or with yourself, or the advanced practitioner if the doctor is not there. So being part of that, examining the ladies maybe. But here, there is enough of us who already do the interventional tests, the procedures and because of the skills we have got with perceiving our images I can't see that you would come in to do FNAs or core biopsies really, because we are already there.

? Solution searching

Role development

Team  
Dynamics

JC Yea ok yea ok. Is there anything else you feel I haven't asked you that you feel you would like to contribute to this interview.

RG1 I feel we have covered most of the ground, its sort of err other things that go on isn't it outside the BASC, but I think what you are asking me is more just the assessment clinic, like localisations and MDMs and things like that?

JC Yes this is purely about the BCN role in the BASC and how we can best explore how we can be best utilised in the most effective way for the clients coming through

RG1 Yes

JC Well I think I can't think of anything else at this moment in time.

RG1 No I feel I've covered it.

JC Ok . Thank you ever so much I appreciate that.

RG1 Can I come back and tell you other things if I think of things in the next day or two, or is it just this interview?

JC I think it will be on just this interview.

RG1 Ok fair enough

(Both Laugh)

JC But if you do think of something, I will need to check it with my supervisor if that is possible. Let me just check if I have gone through everything I need to ask you. I am just looking at my information here, but I just notice did you want to say something extra.

Rg1 Yes just to say I went to South Birmingham to spend some time in their assessment clinic and their BCNs do things very differently to how we do things here

JC Aha

Birmingham  
different  
practice

Variance on  
working  
practice  
beyond our  
clinic  
? useful ??

RG1 They take all their ladies through first and give them a clinical examination and tell them what is going to happen and then they will hand them over to the radiographer to have their films, or they will call the radiologist into do an ultrasound scan. But they will have examined the lady because the radiologist there will not do clinical examinations, because they say they are not trained, but the BCN's are. Sometimes there is a surgeon around as well and he's obviously going to do a clinical examination. But they (BCNs) will routinely take the ladies in and do a clinical examination and talk to them and prepare them for ultrasound if that's what's needed or they will take them through to do the imaging.

JC What are your thoughts about that?

RG1 I just felt they are doing part of the radiologist's role, because I think the radiologist should be doing a clinical examinations so that they know what it is they are going to be doing in ultrasound scan on, or erm the examination probably should follow the x-ray anyway.

JC The clinical examination should follow the X-ray?

RG1 Yes.

JC Right.

RG1 But again it is the order of doing triple assessment and we just do it differently here, cos we have no surgeon in the clinic, whereas they have their surgeon that they pass them on to.

JC Can you just run that through me again. So the BCN brings the patient in.

RG1 Yes

JC And ....

RG1 Talks to them performs a clinical examination, makes a note of that on their form and gets them to have their imaging or gets them to which is in the same room as the ultrasound.

JC So the BCN actually dictates..

RG1 Yes

JC the actual assessment process?

RG1 The start of it, she initiates the assessment process.

JC Based on what?

RG1 They have met the patient first, they have given a clinical opinion on palpation.

They have got that down as part of their first part of the triple assessment.

JC So they would feel something and write down, what would they write down?

RG1 I don't know I can't remember the form, I've got one at home I think to write down what their findings are. Whereas we have it on the back of our sheets don't we, if clinical examination is done. It isn't routinely done for every lady. If it's benign or we proved it was nothing on the film. But they do it there routinely before they do any thing else. But that has just come to mind.

JC How interesting. Ok well thank you very much. I will close the session here.

## **APPENDIX 7**

### **Reflective diary of researcher**

#### **Example one**

##### **INTERVIEW WITH (RG1)**

First interview and seemingly very nervous but excited.

Wasn't sure if RG1 was going to be informative open and honest?

Being a BCN in the same unit was conscious some colleagues may find some difficulty in sharing potential negative issues related to the BCN in BSAC.

However RG1 appeared to be very open and share her concerns about the BCN role specifically around the pre assessment contact. I did encourage openness however was probably unprepared for her response. I was surprised at that she felt this was repetitious of their role and not really useful. I do feel that there is some lack of understanding about the reason for our input at this stage. For me as a BCN this isn't purely about discussing what is going to happen it's about assessing the individuals anxiety about the recall and other issues that may arise and have precipitated clients thoughts feeling etc. It does appear that some BCNs focus on the assessment process and ask the radiographers the findings and imaging process that is being requested. Now I don't tend to that I will look at the form and have some background info otherwise my intervention is client lead and responsive to meet their needs. The question arises do I do things different to other BCNS?

I can understand RG1 reflection on repetition if they feel that is what we as BCN are focussing on. I wonder if she sees any value in BCN input if she were aware of what I perceive the BCN (or me for that does).

I guess it makes me question the value or even if the client finds it valuable.

It will be interesting to hear others views on this.

Over time especially since the introduction of the 4tier system that team dynamics have changed. Previously I felt the BCN played a pivotal role in the BSAC, not sure I feel like that now, can't put my finger on it, could it just be me getting long in the tooth!!!! Confusion over where I need to be, what seemingly are the BCN priorities in this setting? RG1 defines it not as confusion, but fusion of roles is this good or bad is

it ok to over lap on roles or does it create more frustration?

Not sure I felt really comfortable at all in this interview with my techniques. Thought it would be a lot easier than this, just wanted it to be so right, I think I was concentrating on getting right that I lost concentration at times and missed cues. Worried about putting words in to her mouth, however she was quick to correct me when paraphrasing her comments. I was aware of not getting into counsellor mode.

Review techniques with supervisor after next interview.

Interview didn't last as long as anticipated I hope I have asked and probed appropriately. Oh this is scary.

## **Example 2**

Have sent out 20 questionnaires to clients with poor response rate.

Agreed by supervisors that I could approach clients following permission from client agreed with BCN in that clinic who provided an overview of study to client prior to my approach.

Approach agreed to introduce research outline and provide client with information sheet on agreement she is happy to be contacted min 24(however most patients contacted after 7 days) to agree participation. This had positive outcome and was able to recruit with this method.

## **Example 3**

### **Client 2**

Not sure I'm getting useful information from clients on the whole in terms of quality information. Just wonder if this is related to the fact that I am only interviewing clients with normal/benign results and not those with a diagnosis of breast cancer. Not sure if clients truly understand the role or is it my questions that are not eliciting the information. Need to talk with supervisors re prompts to promote more dialogue, or other methods.

Tendency to get little value response from the following questions:

*Q4 What effect do you think the breast care nurse has on the quality of the service being provided?*

*Q5 What do you think would help or assist the breast care nurse to provide a more effective service in the Breast screening Assessment clinic?*

Discussed with supervisor, questions amended to enhance a more detailed response but with same reference to original question. I feel happier about the change.

Q4 *what do you think are the factors that contribute to the quality of care delivered in the BSAC you receive?*

*Does the BCN contribute to that/those?*

*This is my list*

- ☐ *Efficient and timely delivery of service*
- ☐ *Patient education (health promotion/ breast awareness)*
- ☐ *Good communication, skilled sensitive*
- ☐ *Quality information written/ verbal*
- ☐ *Contact details for self referral following BSAC*

*Would you include these as part of the BCN role?*

Q5 How do you think the BCN service might develop in the future?

Feel happier with this format, has promoted greater insight and discussion from recent interviews.